MEDICAL HISTORY STATEMENT – Training Candidate

Kentucky Constable Association, Inc.
Training Division

Instructions:

- Fill out the questionnaire completely and accurately. Keep in mind that all statements are subject to verification; deliberate inaccuracies or incomplete statements may bar or remove you from training. A "yes" answer does not necessarily mean that you will be disqualified.
- This form must be completed and presented annually to the Association Training Division.
- This medical history statement is confidential.
- Type or legibly print (in ink).

SECTION 1: CANDIDATE IDENTIFICATION

1. CANDIDATE'S NAME (Last, First, Middle)	2. SOCIAL SECURITY NUMBER	3. BIRTHDATE (MM/DD/YYYY)
	Last 4 digits:	

4. ADDRESS WHERE YOU CAN BE CONTACTED (Street / P.O. Box)	5. CITY	6. STATE / ZIP

7. PHONE NUMBERS WHERE YOU CAN BE REACHED	8. E-MAIL
Home/Office: ( ) – Mobile: ( ) –	

SECTION 2: JOB HISTORY AND PHYSICAL ACTIVITY

9. List current and all previous jobs held in the last 5 years, including military service.

	JOB TITLE	PRIMARY DUTIES	EMPLOYER	APPROXIMATE DATES
A)				From: To:
B)				From: To:
C)				From: To:
D)				From: To:
E)				From: To:
F)				From: To:
G)				From: To:
H)				From: To:
I)				From: To:

10. Describe your typical physical activity, including that at work. Indicate how often and how long you've been doing it.

	EXERCISE / ACTIVITY	HRS PER WK	HOW LONG?
A)			yrs mos
B)			yrs mos
C)			yrs mos

continues

SECTION 3: MEDICAL HISTORY

Y	N	?	Answer each of the following questions.
☐	☐	☐	11. Have you ever failed to complete a peace officer academy training program?
☐	☐	☐	12. Have you ever been refused employment or been unable to hold a job because of any physical, psychological, or other medically-related reason?
☐	☐	☐	13. Have you ever worked as a peace officer before?
☐	☐	☐	14. Have you ever coughed, or wheezed, or had chest discomfort during or after exercise?
☐	☐	☐	15. Do you have any physical limitations?
☐	☐	☐	16. Have you been rejected for, or discharged from the military because of, physical, mental, or other medically-related reasons?
☐	☐	☐	17. Do you need any reasonable accommodation to assist you in performing required job tasks?
☐	☐	☐	18. Have you ever been absent from work due to job stress?
☐	☐	☐	19. Have you missed more than five days from work in the past 12 months due to medically-related reasons?
☐	☐	☐	20. Have you ever been absent from work because of back/neck pain or problems?
☐	☐	☐	21. Have you ever seen a doctor for back/neck pain or problems?
☐	☐	☐	22. Do you currently have a cold or cough, or have you had either in the past two weeks?
☐	☐	☐	23. In the past year, have you had a change in the size and color of a mole or a sore that would not heal?
☐	☐	☐	24. Do you ever wake up short of breath?
☐	☐	☐	25. Have you ever had any breathing problems using a gas mask? (Check “No” if you have never used a gas mask.)
☐	☐	☐	26. Do you currently smoke cigarettes? IF YES: How many packs per day? For how long (in years)?
☐	☐	☐	27. Are you an ex-smoker? IF YES: How many years did you smoke? Packs per day? Approximate date quit
☐	☐	☐	28. Have you used chewing tobacco or smoked cigars/pipes in the last 15 years?
☐	☐	☐	29. Have you ever had a positive drug or alcohol test?
☐	☐	☐	30. Are you now or have you ever been enrolled in a drug or alcohol rehabilitation program?
☐	☐	☐	31. Per week, I drink: __ bottles/cans of beer __ glasses of wine __ glasses of hard liquor
☐	☐	☐	32. Has anyone ever been concerned about your drinking or suggested that you cut down?
☐	☐	☐	33. Have you ever been convicted of driving under the influence (DUI)?
☐	☐	☐	34. Have you ever felt bad about your drinking?
☐	☐	☐	35. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
			36. I am: ☐ Right-handed ☐ Left-handed
☐	☐	☐	37. Have you ever been hospitalized overnight (except for pregnancy)?
☐	☐	☐	38. Have you had any surgical operations?
☐	☐	☐	39. Have you been exposed to loud noise today? IF YES: Were you wearing hearing protection?
☐	☐	☐	40. Have you sustained any disabling illnesses or medical conditions within the past 5 years?
☐	☐	☐	41. Do you occasionally use, or are you currently taking, any prescription or over-the-counter medications?
☐	☐	☐	42. Have you taken any medication within the past 12 months for any reason?

continues

SECTION 3: MEDICAL HISTORY *continued*

43. Briefly explain any items you marked "yes" or "?." In addition, describe anything else which you feel may be important in evaluating your medical suitability for the position, including any condition(s) not specifically referred to in the preceding questions.

ITEM #	EXPLANATION – USE ADDITIONAL SHEETS IF NECESSARY

continues

SECTION 4: MEDICAL CONDITIONS – Indicate if you have, or ever had, any of the following conditions. If you're unsure, mark "?"

	Y	N	?		Y	N	?		Y	N	?
44. EYE, EAR, NOSE, THROAT											
A) Eye surgery	☐	☐	☐	H) Glaucoma	☐	☐	☐	O) Ringing or buzzing in ears	☐	☐	☐
B) Refractive surgery (e.g., Lasik, PRK)	☐	☐	☐	I) Blurred or double vision	☐	☐	☐	P) Decreased hearing	☐	☐	☐
C) Orthokeratology / retainer lenses	☐	☐	☐	J) Abnormal color vision test	☐	☐	☐	Q) Ear surgery	☐	☐	☐
D) Vision therapy	☐	☐	☐	K) Sinus trouble	☐	☐	☐	R) Earache	☐	☐	☐
E) Vision impairment	☐	☐	☐	L) Loss of smell	☐	☐	☐	S) Abnormal audiogram	☐	☐	☐
F) Need to wear corrective lenses	☐	☐	☐	M) Allergy / Hay fever	☐	☐	☐				
G) Cataracts	☐	☐	☐	N) Ruptured ear drum	☐	☐	☐				
45. RESPIRATORY											
A) Asthma (age at last episode: ____)	☐	☐	☐	D) Positive TB skin test	☐	☐	☐	G) Chest tightness	☐	☐	☐
B) Shortness of breath	☐	☐	☐	E) Coughed up blood	☐	☐	☐	H) Wheezing	☐	☐	☐
C) Chronic or frequent cough	☐	☐	☐	F) Pneumothorax (collapsed lung)	☐	☐	☐	I) Blood clot in lung	☐	☐	☐
46. GASTROINTESTINAL											
A) Ulcer / Stomach trouble	☐	☐	☐	F) Gall bladder trouble	☐	☐	☐	K) Abnormal liver test / Liver disease	☐	☐	☐
B) Vomited blood	☐	☐	☐	G) Hepatitis	☐	☐	☐	L) Hernia	☐	☐	☐
C) Persistent diarrhea	☐	☐	☐	H) Mucous in stool	☐	☐	☐	M) Irritable Bowel Syndrome	☐	☐	☐
D) Colitis	☐	☐	☐	I) Black / bloody bowel movement	☐	☐	☐	N) Crohn's disease	☐	☐	☐
E) Recurrent hemorrhoids	☐	☐	☐	J) Pancreatitis	☐	☐	☐				
47. GENITOURINARY											
A) Kidney disease or stone	☐	☐	☐	D) Blood in urine	☐	☐	☐	G) Menstrual discomfort that kept you from work	☐	☐	☐
B) Bladder trouble	☐	☐	☐	E) Prostatitis	☐	☐	☐	H) Currently pregnant	☐	☐	☐
C) Difficulty urinating	☐	☐	☐	F) Irregular vaginal bleeding	☐	☐	☐				
48. CARDIOVASCULAR											
A) Heart attack	☐	☐	☐	E) Enlarged heart	☐	☐	☐	I) Rheumatic fever	☐	☐	☐
B) Heart murmur	☐	☐	☐	F) Palpitation (irregular heartbeat)	☐	☐	☐	J) Swelling of foot or leg	☐	☐	☐
C) Heart failure	☐	☐	☐	G) High blood pressure	☐	☐	☐	K) Painful varicose veins	☐	☐	☐
D) Heart valve abnormality	☐	☐	☐	H) Pain or discomfort in chest	☐	☐	☐				
49. MUSCULOSKELETAL											
A) Fracture / Broken bone	☐	☐	☐	C) Neck trouble / pain	☐	☐	☐	E) Arthroscopy	☐	☐	☐
B) Back trouble / pain	☐	☐	☐	D) Shin pain	☐	☐	☐	F) Arthritis / Rheumatism	☐	☐	☐
50. JOINT INJURY / SURGERY / DISLOCATION / PAIN / SWELLING											
A) Shoulder	☐	☐	☐	D) Fingers / Toes	☐	☐	☐	G) Ankle / Foot	☐	☐	☐
B) Elbow	☐	☐	☐	E) Hip	☐	☐	☐	H) Other joint pain or swelling	☐	☐	☐
C) Wrist	☐	☐	☐	F) Knee	☐	☐	☐				

continues

SECTION 4: MEDICAL CONDITIONS *continued*

51. NEUROLOGICAL

	Y	N	?		Y	N	?		Y	N	?
A) Epilepsy	☐	☐	☐	F) Head injury	☐	☐	☐	K) Skull defect	☐	☐	☐
B) Convulsion / Seizure	☐	☐	☐	G) Loss of consciousness	☐	☐	☐	L) Tremors	☐	☐	☐
C) Fainting spells / Blackouts	☐	☐	☐	H) Frequent / recurrent headaches	☐	☐	☐	M) Meningitis / Encephalitis	☐	☐	☐
D) Recurrent dizziness	☐	☐	☐	I) Migraine / Sinus headaches	☐	☐	☐	N) Numbness of extremities	☐	☐	☐
E) Carpal Tunnel Syndrome	☐	☐	☐	J) Multiple Sclerosis	☐	☐	☐				

52. MISCELLANEOUS

A) Diabetes	☐	☐	☐	I) Cancer / Leukemia	☐	☐	☐	Q) Recurrent fever in the last year	☐	☐	☐
B) Low blood sugar	☐	☐	☐	J) Wool allergy	☐	☐	☐	R) Eczema	☐	☐	☐
C) Thyroid trouble	☐	☐	☐	K) Non-healing sores	☐	☐	☐	S) Claustrophobia	☐	☐	☐
D) Bleeding tendencies	☐	☐	☐	L) Chronic fatigue	☐	☐	☐	T) Sleep apnea	☐	☐	☐
E) Anemia	☐	☐	☐	M) Night sweats	☐	☐	☐	U) Snoring	☐	☐	☐
F) Enlarged glands	☐	☐	☐	N) Undesired weight loss or gain	☐	☐	☐	V) Sleep problems / disorders	☐	☐	☐
G) Cyst / tumor	☐	☐	☐	O) Heat stress	☐	☐	☐	W) Any other problem or illness not listed that may affect job performance	☐	☐	☐
H) Skin problems / rashes	☐	☐	☐	P) Multiple chemical sensitivity	☐	☐	☐				

53. Explain any medical conditions you marked "yes" or "?." Reference the corresponding item number and letter in your response (*for example,* 46B, 50F, etc.).

ITEM #	EXPLANATION – USE ADDITIONAL SHEETS IF NECESSARY

continues

SECTION 5: CANDIDATE CONSENT

I hereby authorize the performance of a complete medical examination, x-rays, blood testing, and urine testing. I am aware that laboratory testing may be used to detect illegal substances and therapeutic medications, and to verify my answers to the questions contained in this medical questionnaire. I also authorize the medical examiner to obtain current or past medical records and to discuss my medical status and history with my treating physician or other medical consultants as necessary. I declare that my answers are true to the best of my knowledge and belief. I am aware that any willful inaccuracy may be regarded as cause for disqualification for Training.

SIGNATURE IN FULL ▶	DATE

SECTION 6: EXAMINING PHYSICIAN'S COMMENTS / NOTES

ITEM #	COMMENTS / NOTES