04/2018

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

927 Centennial Way, PO Box 30633, Lansing MI 48909
517-636-7864

MEDICAL HISTORY STATEMENT

NOTE: After the medical examination is completed, the Medical History Statement should be retained by the examining physician or the law enforcement agency. Do not forward this form to the Michigan Commission on Law Enforcement Standards unless requested by MCOLES.

The Michigan Administrative code of 1979, as amended, requires that law enforcement officer applicants be examined by a licensed physician to ensure that the applicant is free of any physical defect or medical condition which might adversely affect job performance or endanger the life of the officer or others. Rules 28.14206(1)(c), 28.14207(f) and 28.14312(3) require that a declaration of the applicant's medical history be made available to the examining physician.

The information you provide in this statement is extremely important. It will be used by the examining physician to evaluate your medical fitness for the position of entry-level law enforcement officer. Therefore, please fill out the questionnaire completely and accurately. Please keep in mind that: (a) all statements are subject to verification, and (b) deliberate inaccuracies or incomplete statements may bar or remove you from employment.

This statement was designed to explore those areas that bear directly upon the physical demands of the position for which you are applying. A thorough and accurate evaluation of this information will contribute to sound employment decisions benefiting both you and your potential employer.

This statement is confidential. If hired, the information you provide will be a part of your medical record.

When answering "Yes" or "No" questions, place an "X" in the appropriate space. If you are unable to answer a question for any reason you will need to discuss the issue with the examining physician.

Type or print only:

Name: Last:	First:	Middle:	Suffix (Jr, Sr, III):
Social Security No.*:	Date of Birth:	Primary Phone No.:	Alternate Phone No.:
Residence Address (Street, City, State, Zip):			

I, the undersigned, do hereby consent to undergo a medical examination, including blood specimens, x-rays, skin tests, immunizations, and other examinations which the examiners may consider necessary to complete the medical evaluation.	
Signature:	Today's Date:

AUTHORITY:	203 PA 1965
COMPLIANCE:	Voluntary
PENALTY:	No License Activation/ Academy Enrollment

* This information is confidential. Confidential information is protected by the Federal Privacy Act. If necessary, the Social Security Number will be used for identification purposes to ensure that proper records are obtained.

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1. Have you been medically examined for employment with this agency before? ☐ Yes ☐ No

2. List all medications you regularly use, including vitamins, birth control pills, laxatives, aspirations, antihistamines, tranquilizers, and weight reducing aids.

   a. _____ b. _____ c. _____

   d. _____ e. _____ f. _____

3. List any medications you have taken in the last 2 months (prescription and non-prescription).

   a. _____ b. _____ c. _____

   d. _____ e. _____ f. _____

4. Name any drugs to which you may have ever had an allergic reaction.

   a. _____ b. _____ c. _____

5. List any other substances to which you are allergic, including food, insect stings, etc.

   a. _____ b. _____ c. _____

6. List your last 3 hospitalizations, beginning with the most recent (excluding routine childbirth).

	Reason:	Hospital/City:	Month/Year:
a.			
b.			
c.			

7. List any operations you may have had which are not listed above.

	Reason:	Hospital/City:	Month/Year:
a.			
b.			
c.			

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8.	Have you been rejected by the military for health reasons?	☐ Yes	☐ No
9.	Were you ever in the Armed Services? If "YES", answer number 9a.	☐ Yes	☐ No
	9a. Did you receive a medical discharge?	☐ Yes	☐ No
10.	Have you ever made a claim for an occupational disease?	☐ Yes	☐ No
11.	Have you ever made a claim for an industrial accident?	☐ Yes	☐ No
12.	Have you any claim now pending for any of the above?	☐ Yes	☐ No
13.	Do you have an educational or learning disability?	☐ Yes	☐ No

If you have ever had or now have any of the following, check the appropriate box(es).

14.	Allergic rhinitis	☐ Yes	☐ No	31.	Hypothyroidism	☐ Yes	☐ No
15.	Anemia	☐ Yes	☐ No	32.	Kidney disease	☐ Yes	☐ No
16.	Asthma	☐ Yes	☐ No	33.	Liver trouble or hepatitis	☐ Yes	☐ No
17.	Bronchitis	☐ Yes	☐ No	34.	Phlebitis	☐ Yes	☐ No
18.	Cancer	☐ Yes	☐ No	35.	Pneumonia	☐ Yes	☐ No
19.	Diabetes (sugar disease)	☐ Yes	☐ No	36.	Rheumatic Fever	☐ Yes	☐ No
20.	Duodenal or stomach ulcer	☐ Yes	☐ No	37.	Rheumatism, arthritis	☐ Yes	☐ No
21.	Emphysema	☐ Yes	☐ No	38.	Scarlet fever	☐ Yes	☐ No
22.	Encephalitis, meningitis	☐ Yes	☐ No	39.	Sickle cell disease	☐ Yes	☐ No
23.	Gall bladder trouble	☐ Yes	☐ No	40.	Tuberculosis	☐ Yes	☐ No
24.	Glaucoma	☐ Yes	☐ No	41.	Typhoid fever	☐ Yes	☐ No
25.	Hay fever	☐ Yes	☐ No	42.	Valley fever	☐ Yes	☐ No
26.	Heart murmur, heart disease	☐ Yes	☐ No		(coccidioidomycosis)	☐ Yes	☐ No
27.	Hiatal or diaphragmatic hernia	☐ Yes	☐ No	43	Varicose veins	☐ Yes	☐ No
28.	High blood pressure	☐ Yes	☐ No	44.	Venereal disease(s)	☐ Yes	☐ No
29.	Histoplasmosis	☐ Yes	☐ No		(e.g. STDs, HIV, AIDS, etc.)		
30.	Hyperthyroidism	☐ Yes	☐ No				

45. Other (explain):

46.	Have you gained or lost more than 10 lbs. in the past 2 years without trying to do so?	☐ Yes	☐ No
47.	Have you had any changes in your appetite in the past 6 months?	☐ Yes	☐ No
48.	Have you noticed unusual fatigue or weakness recently?	☐ Yes	☐ No
49.	Have you been told by a doctor that you had trouble with your thyroid gland?	☐ Yes	☐ No
50.	Have you noticed changes in your hair or skin color or texture?	☐ Yes	☐ No
51.	Have you had a change in size or color of a mole (dark growth) or wart in the past year?	☐ Yes	☐ No

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52.	Do you have a skin rash, burning, itching or other skin sensitivity?	☐ Yes	☐ No
53.	Have you had any skin cancers removed?	☐ Yes	☐ No

54.	Have you had bleeding gums in the past year?	☐ Yes	☐ No
55.	Do you have frequent nosebleeds for no apparent reason?	☐ Yes	☐ No
56.	Do you frequently have sinus trouble?	☐ Yes	☐ No
57.	Do you have colds more than twice a year?	☐ Yes	☐ No
58.	Have you ever coughed up blood?	☐ Yes	☐ No

59.	Have you had a chest X-ray in the past 2 years?	☐ Yes	☐ No
60.	Do you often cough up a large amount of mucus?	☐ Yes	☐ No
61.	Have you ever had a positive TB (tuberculosis) skin test?	☐ Yes	☐ No
62.	Do you have unusual shortness of breath?	☐ Yes	☐ No
63.	Do your ankles or feet often swell?	☐ Yes	☐ No
64.	Have you had a feeling of pressure of tightness in your chest in the past year?	☐ Yes	☐ No
65.	Have you had pain in your chest in the past year?	☐ Yes	☐ No
66.	Do you sometimes wake up at night short of breath?	☐ Yes	☐ No
67.	Do you get pains or cramps in the back of your legs while walking?	☐ Yes	☐ No
68.	Do you get pains or cramps in your legs at night?	☐ Yes	☐ No
69.	Do you smoke cigarettes? If "Yes", how many packs per day? _____ packs/day	☐ Yes	☐ No
70.	Do you use any other forms of tobacco (e.g., cigars, pipe, snuff, etc.)?	☐ Yes	☐ No
	70a. If "YES", what form? _____		
71.	Do you sometimes have severe soakings sweats at night?	☐ Yes	☐ No
72.	Have you had an electrocardiogram (ECG, EKG) in the past 2 years?	☐ Yes	☐ No

73.	Do you suffer from indigestion?	☐ Yes	☐ No
74.	Is swallowing painful or difficult for you?	☐ Yes	☐ No
75.	Do you frequently have pain in your stomach or abdomen?	☐ Yes	☐ No
76.	Do you frequently take antacid medications, such as Tums or Rolaids?	☐ Yes	☐ No
77.	Have you vomited blood or coffee ground-like material?	☐ Yes	☐ No
78.	Are your bowel movements ever black or bloody?	☐ Yes	☐ No
79.	Are your bowel movements ever painful?	☐ Yes	☐ No
80.	Have you ever had hemorrhoids?	☐ Yes	☐ No

81.	Do you frequently get up at night to urinate?	☐ Yes	☐ No
82.	Do you ever have difficulty stopping or starting urination?	☐ Yes	☐ No
83.	Have you had pain or burning with urination?	☐ Yes	☐ No

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84.	Has your urine ever been red, black, brown, or bloody?	☐ Yes	☐ No
85.	Have you eve been told by a doctor that you had sugar or pus in your urine?	☐ Yes	☐ No
86.	Have you ever had a bladder or kidney infection?	☐ Yes	☐ No
87.	Have you ever passed a kidney stone?	☐ Yes	☐ No
88.	Have you ever had a hernia (rupture)?	☐ Yes	☐ No

89.	Have you ever had a minor neck or back sprain? If "YES", answer the following questions.	☐ Yes	☐ No
	89a. How many times have you had an attack of this condition?	____	
	89b. How many days were you unable to work because of this condition?	____	
90.	Have you ever had a severe neck or back injury or an episode of severe neck or back pain? If "Yes", answer the following questions.	☐ Yes	☐ No
	90a. How many times have you had an attack of this condition?	____	
	90b. How many days were you unable to work because of this condition?	____	
91	Have you had problems with low back pain?	☐ Yes	☐ No
92	Have you ever experienced muscle injuries?	☐ Yes	☐ No
	92a. How many times have you had a pulled muscle?	____	
	92b. How many times have you had a torn muscle?	____	
93.	Have you ever had a problem with any bones or joints, including fractures, dislocations, limitations of movement, stiffness, or pain? If "YES" describe the problem below.	☐ Yes	☐ No

94.	Have you had any fainting spells?	☐ Yes	☐ No
95.	Have you had any seizures or epilepsy?	☐ Yes	☐ No
	95a. If "Yes", how many times?	____	
	95b. When was the last incident?	____	
96.	Have you had a skull fracture or a head injury?	☐ Yes	☐ No
	96a. If "Yes", did you experience a loss of consciousness?	☐ Yes	☐ No
97.	Have you ever experienced a concussion?	☐ Yes	☐ No
	97a. If "Yes", how many times?	____	
	97b. When was the last incident?	____	
98.	Have you ever had an Electroencephalogram (EEG)?	☐ Yes	☐ No
99.	Do you suffer from migraine headaches or other bad headaches?	☐ Yes	☐ No
100.	When you have a headache is it relieved by aspirin?	☐ Yes	☐ No

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101. Do you have earaches or ear infections often?	☐ Yes	☐ No
102. Do you have ringing or buzzing noises in your ears?	☐ Yes	☐ No
103. Do you sometimes have difficulty hearing what is said to you?	☐ Yes	☐ No
104. Have you ever been prescribed hearing aids?	☐ Yes	☐ No

105. Have you had any serious eye infections or injury?	☐ Yes	☐ No
106. Does your eyesight ever blur?	☐ Yes	☐ No
107. Have you had any sudden loss in your vision?	☐ Yes	☐ No
108. Have you ever been prescribed glasses or contact lenses?	☐ Yes	☐ No

109. Are you currently suffering from a mental or emotional problem (e.g. depression, PTSD)?	☐ Yes	☐ No
110. Have you ever had counseling for a mental or emotional problem?	☐ Yes	☐ No
111. Have you ever been diagnosed as having a mental or emotional or mental disorder/illness?	☐ Yes	☐ No
112. Have you ever been hospitalized for treatment of a psychological condition?	☐ Yes	☐ No
113. Have you ever taken a prescription drug to treat a psychological condition?	☐ Yes	☐ No
114. Have you ever been treated or received counseling for an alcohol abuse problem?	☐ Yes	☐ No
115. Have you ever received treatment for the use of recreational drugs and/or the abuse of prescription drugs?	☐ Yes	☐ No
116. Have you ever taken steroids or human growth hormones?	☐ Yes	☐ No
117. If you answered "Yes" to any of the questions for numbers 109-116, please describe below.		

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MEN ONLY

118. Have you ever been told by a doctor that you had prostate trouble?	☐ Yes	☐ No
119. Have you ever had an infection in your prostate gland?	☐ Yes	☐ No
120. Have you ever had a swelling or pain in your scrotum or testicles?	☐ Yes	☐ No

WOMEN ONLY

121. Do you have monthly menstrual periods?	☐ Yes	☐ No
121a. What was the date of your last period?		
122. Are your menstrual periods painful?	☐ Yes	☐ No
122a. What was the date of your last pap smear?		
123. Have you ever noticed any unusual lumps in your breast?	☐ Yes	☐ No
124. Have you ever noticed a discharge from your nipples when you were neither pregnant nor nursing?	☐ Yes	☐ No
125. How many times have you been pregnant?		
126. Have you ever had complications during pregnancy or following the delivery of a child?	☐ Yes	☐ No
127. Are you pregnant now or believe you may be pregnant?	☐ Yes	☐ No

128. Describe anything else which you feel may be important in your medical history, including any conditions not specifically referred to in the preceding questions.

I hereby certify that all statements made in this Medical History Statement are *true* and *complete*, and I understand that any misstatements of material facts may subject me dismissal from training, denial of licensing, or revocation of my law enforcement license.

_____	_____
Signature	**Date Completed**