

MICHIGAN COMMISSION ON LAW ENFORCEMENT STANDARDS

106 West Allegan Suite 600, Lansing MI 48933
(517) 322-6525

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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).						
	<u>Reason:</u>	<u>Hospital/City:</u>	<u>Month/Year:</u>				
	a. _____	_____	_____				
	b. _____	_____	_____				
	c. _____	_____	_____				
7.	List any operations you may have had which are not listed above.						
	<u>Reason:</u>	<u>Hospital/City:</u>	<u>Month/Year:</u>				
	a. _____	_____	_____				
	b. _____	_____	_____				
	c. _____	_____	_____				
8.	If a parent, grandparent, brother or sister has had any of the following diseases, check the appropriate box(es). (M - Mother, F- Father, O - Other)						
	M	F	O		M	F	O
a. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Hereditary or familial disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

If you have ever had or now have any of the following, check the appropriate box(es).		
15. Allergic rhinitis	<input type="checkbox"/> Yes	32. Hypothyroidism
16. Anemia	<input type="checkbox"/> Yes	33. Kidney disease
17. Asthma	<input type="checkbox"/> Yes	34. Liver trouble or hepatitis
18. Bronchitis	<input type="checkbox"/> Yes	35. Phlebitis
19. Cancer	<input type="checkbox"/> Yes	36. Pneumonia
20. Diabetes (sugar disease)	<input type="checkbox"/> Yes	37. Rheumatic Fever
21. Duodenal or stomach ulcer	<input type="checkbox"/> Yes	38. Rheumatism, arthritis
22. Emphysema	<input type="checkbox"/> Yes	39. Scarlet fever
23. Encephalitis, meningitis	<input type="checkbox"/> Yes	40. Sickle cell disease
24. Gall bladder trouble	<input type="checkbox"/> Yes	41. Tuberculosis
25. Glaucoma	<input type="checkbox"/> Yes	42. Typhoid fever
26. Hay fever	<input type="checkbox"/> Yes	43. Valley fever
27. Heart murmur, heart disease	<input type="checkbox"/> Yes	(coccidioidomycosis)
28. Hiatal or diaphragmatic hernia	<input type="checkbox"/> Yes	44. Varicose veins
29. High blood pressure	<input type="checkbox"/> Yes	45. Venereal disease(s)
30. Histoplasmosis	<input type="checkbox"/> Yes	(e.g. STDs, HIV, AIDS, etc.)
31. Hyperthyroidism	<input type="checkbox"/> Yes	
46. Other (explain):		

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

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53. Do you have a skin rash, burning, itching or other skin sensitivity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
54. Have you had any skin cancers removed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

55. Have you had bleeding gums in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
56. Do you have frequent nosebleeds for no apparent reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
57. Do you frequently have sinus trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
58. Do you have colds more than twice a year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
59. Have you ever coughed up blood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

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

82. Do you frequently get up at night to urinate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
83. Do you ever have difficulty stopping or starting urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
84. Have you had pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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85. Has your urine ever been red, black, brown, or bloody?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
86. Have you ever been told by a doctor that you had sugar or pus in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
87. Have you ever had a bladder or kidney infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
88. Have you ever passed a kidney stone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
89. Have you ever had a hernia (rupture)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
90. Have you ever had a minor neck or back sprain? If "YES", answer the following questions.	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 ever had a severe neck or back injury or an episode of severe neck or back pain? If "Yes", answer the following questions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
91a. How many times have you had an attack of this condition?	_____	
91b. How many days were you unable to work because of this condition?	_____	
92. Have you had problems with low back pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
93. Have you ever experienced muscle injuries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
93a. How many times have you had a pulled muscle?	_____	
93b. How many times have you had a torn muscle?	_____	
94. 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
95. Have you had any fainting spells?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
96. Have you had any seizures or epilepsy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
96a. If "Yes", how many times?	_____	
96b. When was the last incident?	_____	
97. Have you had a skull fracture or a head injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
97a. If "Yes", did you experience a loss of consciousness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
98. Have you ever experienced a concussion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
98a. If "Yes", how many times?	_____	
98b. When was the last incident?	_____	
99. Have you ever had an Electroencephalogram (EEG)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
100. Do you suffer from migraine headaches or other bad headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
101. When you have a headache is it relieved by aspirin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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102. Do you have earaches or ear infections often?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
103. Do you have ringing or buzzing noises in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
104. Do you sometimes have difficulty hearing what is said to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
105. Have you ever been prescribed hearing aids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
106. Have you had any serious eye infections or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
107. Does your eyesight ever blur?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
108. Have you had any sudden loss in your vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
109. Have you ever been prescribed glasses or contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
110. Are you currently suffering from a mental or emotional problem (e.g. depression, PTSD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
111. Have you ever had counseling for a mental or emotional problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
112. Have you ever been diagnosed as having a mental or emotional or mental disorder/illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
113. Have you ever been hospitalized for treatment of a psychological condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
114. Have you ever taken a prescription drug to treat a psychological condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
115. Have you ever been treated or received counseling for an alcohol abuse problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
116. Have you ever received treatment for the use of recreational drugs and/or the abuse of prescription drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
117. Have you ever taken steroids or human growth hormones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
118. If you answered "Yes" to any of the questions for numbers 110-117, please describe below.		

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MEN ONLY

119. Have you ever been told by a doctor that you had prostate trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
120. Have you ever had an infection in your prostate gland?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
121. Have you ever had a swelling or pain in your scrotum or testicles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

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

129. 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.

<hr/> Signature	<hr/> Date Completed
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