

MEDICAL HISTORY STATEMENT

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS.

INSTRUCTIONS:

To be completed by applicant for a position as a law enforcement officer prior to the physical examination and pr esented to the examining physician at the time of examination. All questions must be ans wered completely and accurately. The original or a copy must be retained in a personnel file by the appointing agency.

| DATE: | · | |
|---|-------------------------------------|--|
| Name: | First | Date of Birth:// |
| | | |
| Address: | | |
| City: | State: | Zip Code: |
| Telephone#:()_ | | SS# (Last 4 digits only) |
| CURRENT MEDICATION Prescription Medication | IONS ns: (Include pain relievers | s, birth control pills, etc.) |
| Reason for taking I | Medications listed abo | ove. |
| Over the Counter Med | ications: (Include all cold | d, allergy, headache, vitamins, etc.) |
| ALLERGIES Drug Allergies: (Includ | e your reaction to the med | dication) |
| | | |
| | | |
| All Other Allergies: f | food, insects, seasons, a | animals, materials, etc.: (include reaction) |
| | | |
| | | |

TC-005

| | | ISTORY List ALL hospitalizations and operations since childhood: gery, date of surgery, any complications or other significant information) |
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| | | |
| Have you | ı EVER, ir | n your life, had any of the following types of medical problems: [check all that apply to you] |
| [] | 1. | CANCER: any type of cancer including skin cancer, breast cancer, and leukemia? |
| [] | 2. | MAJOR INFECTIOUS DISEASE: such as tuberculosis, hepatitis, HIV/AIDS, rheumatic fever and |
| r 1 | • | others? |
| [] | 3. | NEUROLOGICAL PROBLEMS : such as seizure disorder, stroke, concussion, severe headache, skull fracture, recurrent vertigo, balance problems, encephalitis, meningitis, tremors, multiple |
| | | sclerosis, Huntington's chorea, peripheral neuropathy and others? |
| [] | 4. | PSYCHOLOGICAL PROBLEMS: such as depression, manic episodes, psychotic episodes, post |
| | | traumatic stress disorder and others? |
| [] | 5. | EYE PROBLEMS: such as eye injury, color blindness, poor night vision (night blindness), |
| | | glaucoma, blindness in one or both eyes, very poor vision when not corrected and others? |
| [] | | EAR PROBLEMS : such as injury, chronic or long lasting infection, use of a hearing aid. |
| [] | 7. | NOSE PROBLEMS: such as nose injury, allergies, nasal bleeding, loss of sense of smell, chronic |
| [] | 8 | or long lasting infections and others? MOUTH OR THROAT PROBLEMS: such as injury, major dental work, any kind of speech defect, |
| LJ | 0. | chronic or long lasting infections, abnormality of nose, mouth or throat that would interfere with |
| | | wearing a respirator and others? |
| [] | 9. | LUNG PROBLEMS: such as asthma, emphysema, chronic or recurrent bronchitis, pneumonia, |
| | | tuberculosis or lung abscess and others? |
| [] | 10. | HEART AND CIRCULATION PROBLEMS: such as a heart murmur, heart disease, heart attack, |
| | | irregular rhythm, valve abnormalities, varicose veins, phlebitis, peripheral vascular disease, |
| гі | 11 | Raynaud's disease and others? DIGESTIVE SYSTEM PROBLEMS: such as any kind of ulcer disease, hepatitis or liver disorder, |
| [] | | any kind of colitis, Crohn's disease, ulcerative colitis, irritable bowel syndrome, esophageal |
| | | disorders, pancreatitis, gall stones, stomach or intestinal bleeding and others? |
| [] | 12. | HORMONE OR ENDOCRINE PROBLEMS: such as diabetes, thyroid disease, parathyroid or |
| | | adrenal problems and others? |
| [] | 13. | . URINARY TRACT PROBLEMS: such as kidney stones, pyelonephritis (kidney infection), nephrosis |
| | | single functioning kidney, polycystic kidney disease, repeated bladder infections and others? |
| [] | | HERNIA: such as inguinal, umbilical, ventral, femoral, hiatal or incisional hernias? |
| LJ | 15. | . MUSCLE, BONE AND JOINT PROBLEMS : such as chronic back or neck pain, fibromyalgia, back or neck disk disease, osteomyletis (bone infection), muscular dystrophy, arthritis, spinal curvature, |
| | | loss of a finger or toe, knee injuries, and others. |
| [] | 16. | BLOOD SYSTEM PROBLEMS: such as anemia, hemophilia or bleeding disorder, white blood cell |
| | | abnormality and others? |
| MALES (| ONLY: | · |
| [] | | Prostrate problems such as enlargement or prostatitis? |
| [] | 18. | . Genital problems such as epididymitis or testicular injury? |
| FEMALE | S ONLY: | |
| [] | | . Currently pregnant? |
| [] | 20. | . History of endometriosis, pelvic inflammatory disease, abnormal Pap smear, PMS or other problem |
| г 1 | 04 | with your menstrual cycle? |
| L J [] | | How many pregnancies have you had? . How many live births have you had? |

| IMN | MUNIZATIONS | |
|--------------------------|-------------------|--|
| [] | | . Have you ever had a positive TB test? |
| [] | | . Have you received Hepatitis B vaccinations? When did you receive your last totanus (lockiaw) immunization? |
| L | 25. | . When did you receive your last tetanus (lockjaw) immunization? |
| | | |
| ОС | CUPATIONAL I | |
| | | rer been exposed to any of the following, whether at home, work, military or any other setting: |
| Г | [check any th | пат арргуј . Repetitive Loud Noises (Including guns, jet engines, loud machinery)? |
| : | 27. | Chemical exposure to skin or lungs? |
| [] [] [] | 28. | . Dusty conditions (sandblasting, grinding, mining or drilling of rock, coal, silica, asbestos)? |
| | | ES answers: (If yes, explain below.) |
| [] | | . Have you ever received or applied for a pension or compensation because of a disability |
| | | or injury? If, yes what percentage?% |
| [] | 30. | . Have you ever missed any work because of back or neck discomfort? |
| | • | 30a. If yes, how many days of work last year did you miss? |
| | | 30b. If yes, how many days a year do you have back or neck pain? |
| ļ . | 31. | Have you ever had a motor vehicle accident causing back or neck pain? |
| [] [] [] [] | 3∠. 32 | Are you limited or unable to perform any physical activity because of muscle or joint discomfort? Do you have any missing limbs or non-functioning joints? |
| L. Г | 33. 34 | . Bo you have any missing limbs of non-tunctioning joints? . Have you ever been advised by a physician to avoid lifting above a certain weight limit? |
| [| , 35. | Have you ever been advised by a physician to avoid sitting or standing over a certain time? |
| [| 36. | . Have you ever worked in law enforcement? |
| | |]36a. If yes, have you ever missed more than three consecutive days of work for any medical or |
| | _ | psychological problem? |
| [] | | . Have you ever served in any of the armed forces? |
| | [|]37A. If yes, have you ever missed more than three consecutive days of service for any medical or psychological problem? |
| [] | | . Do you have any difficulty in properly holding, aiming or firing a handgun, rifle or shotgun? |
| [] | | . Do you have any difficulty driving at high speeds in a motorized vehicle? |
| [] | | . Have you ever had an automobile accident while driving over sixty (60) miles per hour? |
| Ļ . | | . Have you ever had any automobile accidents as a result of losing control of your vehicle? |
| ļ . | | Do you have any difficulty driving for three (3) consecutive hours without stopping? |
| L . | | Do you have any difficulty running for five (5) consecutive minutes without stopping? Have you ever passed out, temporarily lost control of any part of your body, or had blackout spells |
| ι. | , 44 . | (episodes you do not remember)? |
| | | |
| | | F ANY YES ANSWERS: (Identify by number and use additional paper if necessary) |
| | | sheets of paper; write name, last 4 SS#, sign and date. ions or limitations which exist. |
| IIICI | due any restricti | ions of infiltations which exist. |
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| PENALTY : Any falsification, withholding or failure to answer all question receiving or retaining employment or certification as a Nebraska I | |
|---|-------------|
| CERTIFICATION : I hereby certify that there are no willful misrepresentations, omi answers to questions, and that all statements and answers are tree. | <u> </u> |
| Signature of Applicant (ink) | Date Signed |

Date Reviewed

Printed Name and Address of Physician Completing Review

PHYSICIAN REVIEW:

Signature of Physician (ink)



MEDICAL EXAMINATION REPORT

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS.

INSTRUCTIONS:

To be completed by either a physician or surgeon licensed to practice medicine in the State of Nebraska or by a physician or surgeon authorized to practice medicine in accordance with the rules and regulations of the U.S. Armed Forces following an actual physical examination. The original or a copy of this report must be retained in a personnel file by the appointing agency.

| Date: | | | | | | | | | |
|-----------------------------------|-----|-----|------------------|------|----|------|-------------------|-----------------------------------|--|
| Name: | | | | | | | | Date of Birth:/ | |
| Name: Last | | | First | | | | Middle | | |
| Height: | | | | | | | | [] Obese [] Muscular | |
| Visual Acuity: if applic | ant | wea | ars glasses o | r co | nt | tact | s, test and recor | d acuity with and without glasses | |
| Without glasse With glasses: | s: | | R-20 / R-20 / | _ | | | L-20 / L-20 / | Both-20 / Both-20 / | |
| Depth Perception: | [|] | Normal | | [|] | Abnormal: | | |
| Color Perception: | [|] | Normal | | [|] | Abnormal: | | |
| Peripheral Vision: | [|] | Normal | | [|] | Abnormal: | · | |
| HEARING Hearing Acuity: | | | [] Audiogr | am | _ | or - | [] 15' whispere | ed conversation (check one) | |
| Right Ear: | [|] | Normal | | [|] | Abnormal: | | |
| Left Ear: | [|] | Normal | | [|] | Abnormal: | | |
| CARDIOVASCULAR | | | | | | | | | |
| Blood Pressure: | | | | | | | Resting Pulse: | | |
| Cardiac Examination: | [|] | Normal | | [|] | Abnormal: | | |
| Peripheral Circulation: | [|] | Normal | | [|] | Abnormal: | | |
| EKG | [|] | Normal | | [|] | Abnormal: | | |

| | [|] | Н | EAR | T: | | | | | | | | | | | | | | | |
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| | [|] | LI | UNG | :S: | | | | | | | | | | | | | | | |
| | [|] | A | BDO | MEN: | | | | | | | | | | | | | | | - |
| | [|] | M | IUSC | CULOSKELE | TAL: | | | | | | | | | | | | | | |
| | [|] | G | ENI | TOURINARY | ′ : | | | | | | | | | | -111 | | | | |
| | [|] | N | EUR | OLOGICAL: | | | | | | | | | | | | | | | |
| | [|] | S | KIN: | | | | | | | | | | | | | | | | |
| URINAL | .Y: | SIS | [|] | Normal | | [|] | Α | onormal: | | | | | | | | | | _ |
| TB Skin | Т | est | [|] | Negative | | [|] | Р | ositive | | | | | | | | | | |
| EXPLAI May use | NA e a | ATIC addit | ON C | OF A | NY ABNORI eets of paper | MAL F r; write | RE e n | SPC ame | ons e, la | S ES (Ident st 4 SS#, | ify b sign | y Ca and | atego I date | ory). e. | | | | | | |
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| Are th | nere an | у со | nditi | ons, physical, emotiona | al or mental wh | nich, in your opinion, suggest further examination? |
|--------|-----------|----------|-------|---------------------------------|-------------------|---|
| [] | No | [|] | Yes | | |
| | | | | | | |
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| Do yo | No | any [| rese | ervations about this can Yes | ididate's ability | y to physically perform required duties? |
| | | | | | | |
| | | | | | | |
| | | | | | | Name and Address of Physician - Typed |
| Р | hysiciar | n's S | ignat | ture (Must be M.D.) | Date | Name and Address of Physician - Typed |
| | | | | | | |