

# CRIMINAL JUSTICE EDUCATION AND TRAINING STANDARDS COMMISSION

## CRIMINAL JUSTICE STANDARDS DIVISION

Post Office Drawer 149, Raleigh, NC 27602

Telephone: (919) 716-6470

Fax (919) 716-6752



## MEDICAL HISTORY STATEMENT

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

Form F-1(LE)  
(Rev. 10/01)

### INSTRUCTIONS:

To be completed by applicant for a certifiable position prior to the physical examination and presented to the examining physician at the time of examination. All questions must be answered completely and accurately. The original or a copy must be retained in personnel files by the appointing agency.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE # \_\_\_\_\_ SS # \_\_\_\_\_

### CURRENT MEDICATIONS

Prescription Medications: (Include pain relievers, birth control pills, etc.)

Over the Counter Medications: ( Include all cold allergy, headache, vitamins, etc.)

### ALLERGIES

Drug Allergies: (Include your reaction to the medication)

All Other Allergies: food, insects, seasons, animals, materials, etc. : (Include reaction)

(Continued on reverse side)

“The Social Security Number is used to make positive identification of application and/or law enforcement personnel. DISCLOSURE IS VOLUNTARY. However, failure to provide this information may result in a delay in the processing of application materials and may result in inaccurate records being assigned to you.”

## FAMILY HISTORY

Have any of your parents, brothers, or sisters suffered from: [check all that apply]

- Diabetes?
- Heart problems?
- High blood pressure?
- Arthritis?
- Neurologic or psychological problems? (Seizures, depression, schizophrenia, etc.)

## PAST MEDICAL HISTORY

List ALL hospitalizations and operations since childhood:

(Include type of surgery, date of surgery, any complications or other significant information)

Have you EVER, in 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 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?
- 6. **EAR PROBLEMS:** such as ear injury, chronic ringing (tinnitus), chronic or long lasting ear infection, Meniere's disease, moderate to severe hearing loss in one or both ears and others?
- 7. **NOSE PROBLEMS:** such as nose injury, allergies, nasal bleeding, loss of sense of smell, chronic or long lasting infections and others?
- 8. **MOUTH OR THROAT PROBLEMS:** such as injury, major dental work, any kind of speech defect, 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 heart murmur, heart disease, heart attack, irregular rhythm, valve abnormalities, varicose veins, phlebitis, peripheral vascular disease, Raynaud's disease and others?
- 11. **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?
- 14. **HERNIA:** such as inguinal, umbilical, ventral, femoral, hiatal or incisional hernias?
- 15. **MUSCLE, BONE AND JOINT PROBLEMS:** such as chronic back or neck pain, fibromyalgia, back or neck disk disease, osteomyelitis (bone infection), muscular dystrophy, arthritis, spinal curvature, loss of a finger or toe, and others?
- 16. **BLOOD SYSTEM PROBLEMS:** such as anemia, hemophilia or bleeding disorder, white blood cell abnormality and others?

(Continued on next page)

**MALES ONLY:**

- 17. Prostate problems such as enlargement or prostatitis?
- 18. Genital problems such as epididymitis or testicular injury?

**FEMALES ONLY:**

- 19. Currently pregnant?
- 20. History of endometriosis, pelvic inflammatory disease, abnormal Pap smear, PMS or other problem with your menstrual cycle?

**IMMUNIZATIONS**

- 21. Have you ever had a positive TB test?
- 22. Have you received Hepatitis B vaccinations?
- 23. When did you receive your last tetanus (lockjaw) immunization? \_\_\_\_\_

**OCCUPATIONAL HISTORY**

Have you ever been exposed to any of the following, whether at home, work, military or any other setting? [check all that apply]

- 24. Repetitive Loud Noises (Including guns, jet engines, loud machinery)?
- 25. Chemical exposure to skin or lungs?
- 26. Dusty conditions (sandblasting, grinding, mining or drilling of rock, coal, silica, asbestos)?

Check all YES answers:

- 27. Have you ever sustained an injury while at work that necessitated extended care by a health care provider?
- 28. Have you ever had a motor vehicle accident causing back or neck pain?
- 29. Are you limited or unable to perform any physical activity because of muscle or joint discomfort?
- 30. Do you have any missing limbs or non-functional joints?
- 31. Have you ever been advised by a physician to avoid lifting above a certain weight limit?
- 32. Have you ever been advised by a physician to avoid sitting or standing over a certain time?
- 33. Have you ever worked in law enforcement?
- 33a. If yes, have you ever missed more than three consecutive days of work for any medical or psychological problem?
- 34. Have you ever served in any of the armed forces?
- 34a. If yes, have you ever missed more than three consecutive days or service for any medical or psychological problem?
- 35. Do you have any difficulty in properly holding, aiming or firing a handgun, rifle or shotgun?
- 36. Do you have any difficulty driving at high speeds in a motorized vehicle?
- 37. Have you ever had an automobile accident while driving over sixty (60) miles per hour?
- 38. Have you ever had any automobile accidents as a result of losing control of your vehicle?
- 39. Do you have any difficulty driving for three (3) consecutive hours without stopping?
- 40. Do you have any difficulty running for five (5) consecutive minutes without stopping?
- 41. Have you ever passed out, temporarily lost control of any part of your body, or had blackout spells (episodes you do not remember)?

(Continued on reverse side)

**EXPLANATION OF ANY YES ANSWERS:** (Identify by number)  
May use additional sheets of paper; write name, SS #, sign and date.

**PENALTY:**

Any falsification, withholding or failure to answer all questions completely and accurately may disqualify you from receiving or retaining employment or certification as a criminal justice officer.

**CERTIFICATION:**

I hereby certify that there are no willful misrepresentations, omissions or falsifications in the foregoing statements and answers to questions, and that all statements and answers are true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Applicant (Ink)

\_\_\_\_\_  
Date Signed

**PHYSICIAN REVIEW:**

\_\_\_\_\_  
Signature of Physician/Physician's Assistant/Nurse Practitioner(Ink)

\_\_\_\_\_  
Date Reviewed

Printed Name and Address of Physician Physician's Assistant/Nurse Practitioner Completing Review