

STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CRIMINAL JUSTICE
POLICE TRAINING COMMISSION

HEALTH HISTORY STATEMENT

Candidate's Name _____

Last 4 SS No. _____ Date of Birth _____

Candidate's Address: _____

Candidate's Employing Agency _____

Police Training Commission - Approved School Candidate Will Attend:

Name of Course: _____

Course Dates: _____

To the Candidate: Please complete in ink the following questionnaire concerning your past and present health. If you have an electronic copy of this form, it is a fillable .pdf, which can be typed and printed but cannot be saved.

Provide details for any positive answers on this statement.
(You need not explain positive answers for question 16.)
If additional pages are necessary, reproduce the last page.
The information on this form will be used strictly to determine training eligibility and the information will be treated confidentially.

1. Name and address of family doctor _____

2. Date last seen and reason _____

3. Do you use Tobacco products? Yes No What type? _____

How often? _____ Quantity? _____

4. Do you use alcoholic beverages? Yes No If Yes, what is your approximate intake of these beverages?

	None	Occasional	Often	Drinks per week?
Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hard liquor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

5. a. Have you taken any drugs or medications prescribed by a physician in the last year? Yes No
- b. Have you taken any over-the-counter or non-prescription medications in the last year? Yes No
- c. Are you now on any medication? Yes No
6. a. Have you ever undergone a drug test for any employment or admission into a law enforcement training program? Yes No
- b. Have you ever produced a positive result on any drug test reported in 6.a.? Yes No

7. Do you have any hearing problem or deafness? Yes No Explain: _____

8. Do you wear glasses, contact lenses or have any other eye disorder? Yes No Explain: _____

9. Do you have any dental problems? Yes No Explain: _____

10. Have you ever been hospitalized? Yes No If so, when? _____

11. Have you ever had any surgery or operations? Yes No Explain: _____

12. Do you have any physical or mental condition that would prevent you from participating in any form of strenuous, prolonged exercise? Yes No Explain: _____

13. Do you participate in any regular exercise program or sport? Yes No
 Explain: _____

14. Has your weight changed in the last year? Yes No
 How much? _____ (+ or - lbs.)

15. Have you ever experienced any heat stress related emergencies, including heat fatigue, heat cramps, heat exhaustion or heat stroke? Yes No Explain: _____

16. Are you pregnant? Yes No Have you ever been pregnant? Yes No
 Have you given birth during the six-week period of time preceding the start of the basic course? Yes No

17. Have you ever been discharged from the armed services for medical reasons?
 Yes No

Family History

	<u>Age</u>	<u>Health or Cause of Death</u>		<u>Age</u>	<u>Health of Cause of Death</u>
Mother			Father		
Brothers			Sisters		

Heart and Blood Vessels

18. Have you ever had high blood pressure? Yes No When? _____

19. Have you ever had any type of heart trouble (murmur, leaky valve, rheumatic fever, heart attack, coronary?) Yes No Explain _____

20. Do you have any chest pain, skipped heart beats or palpitations? Yes No Explain _____

21. Do you have any kind of circulation problem (cold hands or feet, leg pain while walking, varicose veins, swollen legs or ankles, vein problem, phlebitis)? Yes No Explain _____

22. Have you ever had any type of stroke? Yes No Explain _____

Lung Problems:

23. Have you ever had any lung problem (shortness of breath, chronic cough, wheezing, asthma, emphysema, bronchitis, pneumonia)? Yes No Explain _____

24. Are you now or have you ever used inhalers? Yes No When/how often? _____

Muscle - Bone - Joint Problems

Have you ever had:

25. Any type of back problem (slipped disk, low back strain, back pain, neck pain)?

Explain _____

26. Recurrent dislocations of any joint, recurrent strains or sprains or any type of arthritis?

27. Any athletic or other injury, broken bones, requiring medical attention? _____

Nervous, Mental or Emotional Disorders

28. Have you ever had any nervous or emotional disorders (seizures, fits, epilepsy, blackouts, fainting spells, mental illness, depression, head injury or concussion)?

Yes No Explain _____

Allergies

29. List and explain any allergy problems (food, rash, hay fever, sinus trouble, wheezing, reaction to medicines) _____

Blood Sugar, Blood Tests, Cancer

30 List and explain any high or low blood sugar, abnormal cholesterol, thyroid, anemia or other abnormal blood test, leukemia or cancer _____

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

Details of "Yes" Answers. Include details as to when the condition was treated, and whether treatment was successful. Place appropriate question numbers for responses.

Attach additional pages as necessary.

Question # Details

I understand that this Health History Statement will provide information for the physician to use in assessing my overall health for participation in a commission-approved basic course.

I hereby authorize a copy of this form to be released to the commission-approved school where I am enrolled.

I hereby certify that all statements are accurate and complete. Falsification of information on the Health History Statement may result in dismissal from the commission-approved school.

Signature in full: _____

Date: _____

Print Name in full: _____