



Arizona Peace Officer Standards and Training Board



MEDICAL HISTORY QUESTIONNAIRE

TO THE APPLICANT: Peace officers are required to perform a variety of strenuous and difficult job functions, including those described in the job description for entry level Arizona peace officer. A medical examination, including this form, is required by the Arizona Peace Officer Standards and Training Board prior to appointment as a peace officer. This is to ensure that each applicant is able to safely perform these essential job functions with or without reasonable accommodations. Complete this form prior to your scheduled physical examination as directed by the hiring agency.

NAME: _____
First Middle Last

ADDRESS: _____
Numbers and Street Name City State Zip Code

DATE OF BIRTH: _____ **AGE:** _____ **CURRENT OCCUPATION:** _____
Month/Day/Year

HIRING AGENCY: _____

SECTION A. Have you ever or do you now have any of the following? For "YES" answers, list the question number and supply full details on page 3, the continuation sheet of this form. If the condition required hospitalization, check the corresponding box marked under the title "HOSPITAL".

CONDITION	YES	NO	HOSPITAL	CONDITION	YES	NO	HOSPITAL
1. Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Skin trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back trouble or back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Any complications from childhood diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Any defects of bones or joints (including amputations, broken bones or dislocations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Sensitivity to dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Pernicious anemia or leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Other allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Rheumatism or arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Cancer or malignancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Trick or locked knee/knee injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Tumor, growth or cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Foot trouble or lameness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Eye injury, surgery, or disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever worn glasses/contact lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Heart trouble (including circulatory problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Hard of hearing or hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Mental illness or nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Diabetes or sugar in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Addiction to drugs or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Fainting, dizzy spells, or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Hepatitis, jaundice, or liver ailment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Kidney or bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Disorder of the nervous system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. Hemorrhoids or piles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Tuberculosis or lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Rupture or hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Shortness of breath, asthma or bronchitis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Any type of blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Any contagious disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Any sleeping problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Any immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Print Applicant Name:

SECTION A. Continued - Answer the following questions. For "YES" answers, list the question number and supply full details on page 3, the continuation sheet of this form.

QUESTION	YES	NO
41. Have you ever had or been advised to have an operation?	<input type="checkbox"/>	<input type="checkbox"/>
42. Have you ever been a patient (committed or voluntary) in a mental hospital?	<input type="checkbox"/>	<input type="checkbox"/>
43. Have you ever had any other illness, injury, or physical condition not named on this form other than childhood diseases or minor illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
44. Are you presently under a doctor's care for any condition?	<input type="checkbox"/>	<input type="checkbox"/>
45. Have you taken any medication during the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
46. Do you have any physical or emotional limitations?	<input type="checkbox"/>	<input type="checkbox"/>
47. Do you smoke? If "YES", place the number of packs per day in the following blank: ____	<input type="checkbox"/>	<input type="checkbox"/>
48. Do you drink? If "YES", place the number of drinks per week in the following blank: ____	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICIANS CONSULTED: (For any of the questions answered "YES", identify the question number and physician below.)

DATE	ITEM	PHYSICIAN	Telephone # (Include area code)	ADDRESS (street, city, state, zip code)

SECTION B: ILLEGAL DRUGS or CONTROLLED SUBSTANCES:

List all illegal drugs or controlled substances you have ever used to treat or alleviate the symptoms of a medical condition. This includes marijuana and other controlled substances as well as prescription drugs or medications that were not prescribed for you. (Use page 3, the continuation sheet as needed OR directed below).

On page 3, the continuation sheet of this form please list the following for each drug(s) or controlled substance(s) that you listed above:

Was the use prescribed or recommended by a physician or health care provider? If yes, list the names, address and telephone number of each physician or health care provider who prescribed or recommended the drug or controlled substances.

List the date of the first and last use of the drug or controlled substance.

Describe every way you obtained the drug or controlled substance.

Describe the character of use; include methods of ingestion, location, dosages, frequencies, persons present or those persons with knowledge of the use.

Describe why you stopped using it, if applicable.

State any other factors you believe are relevant to a discussion of your medical condition or the propriety of your drug or controlled substance use.

Other than to actually treat the medical condition, describe any uses of the drug or controlled substances.

I hereby authorize the above listed physician(s) to release any and all medical information to the hiring agency, Arizona POST, its staff or designated representatives.

Signature of Applicant (Sign in Ink)

Date

PENALTY: Any falsification, withholding information or failure to answer all questions completely and accurately may cause forfeiture of eligibility.

CERTIFICATION: I hereby certify that there are no willful misrepresentations, omissions or falsifications in the foregoing statements and answers to the questions, and that all statements and answers are true and correct to the best of my knowledge and belief. I further agree to take any future physical examinations the hiring agency or Arizona POST may deem necessary.

Signature of Applicant (Sign in Ink)

Date

