QUADRANT

MEDICAL HISTORY & EXPOSURES

Name (Print):_____ Date of Birth: _____

Employer: MASSACHUSETTS STATE POLICE

INSTRUCTIONS: Please answer all questions accurately and completely. If you do not understand any question, you should request clarification from the examining provider.

Do you now have or have you ever had any of the following: (Check **Y**es or **N**o)

	Yes	No		Yes	No
1. Fracture of skull, jaw or facial bones			32. Organ transplant		
2. Concussion or other injury to head			33. Liver, pancreas or gall bladder disease		
3. Thoracic outlet syndrome			34. Ulcer or bowel disease		
4. Fracture of neck, vertebrae or spine			35. Intestinal bleeding		
5. Recurrent back or neck pain			36. Hernia of any type		
6. Degenerated or herniated disc			37. Kidney or bladder disease		
7. Back injury or other abnormality			38. Abnormal balance or coordination		
8. Back, spine or neck surgery			39. Fainting, blackouts or dizzy spells		
9. Osteoporosis			40. Stroke, Aneurysm, or Bleeding in head		
10. Arthritis or joint injury or disease			41. Multiple sclerosis or muscular dystrophy		
11. Amputation involving hand or foot			42. Myesthenia gravis or ALS		
12. Carpal tunnel syndrome			43. Epilepsy or seizures		
13. Other hand or wrist problems			44. Dementia or memory loss		
14. Dislocation of any joint			45. Migraines or other severe headaches		
15. Injury or abnormality of arms or legs			46. Paralysis or muscle weakness		
16. Need for corrective lenses			47. Other neurological disorders		
17. Deficiency of color vision			48. Eczema or other skin disease		
18. Disease of the eyes or sinuses			49. Skin grafts		
19. Loss of hearing			50. Bleeding disorder/anticoagulation		
20. Exposure to loud noise			51. Sickle cell disease or trait		
21. Disease of the ear or vertigo			52. Blood clots or thrombosis		
22. Deformity of mouth or jaw			53. High or low blood cell counts		
23. Speech impediment or disorder			54. Enlarged or ruptured spleen		
24. Tuberculosis			55. Diabetes or high blood sugar		
25. Pneumothorax or collapsed lung			56. Thyroid or other endocrine disorder		
26. Lobectomy			57. Cancer, malignancy or tumor		
26. Bronchitis, asthma or other lung disease			58. Mental or emotional disorder		
27. Abnormal electrocardiogram (EKG)			59. Mental health treatment of any type		
28. Heart disease or cardiac abnormality			60. Lupus, scleroderma, dermatomyositis		
29. Irregular heart rhythm			61. Heat stroke, frostbite or burns		
30. Angina/chest pain/shortness of breath			62. AIDS, HIV infection or hepatitis		
31. Hypertension/high blood pressure			63. Are you pregnant?		

Name: _____ Date of Birth: _____

	Yes	No		Yes	No
64. Any history of alcohol or drug abuse			72. Military rejection or medical discharge		
65. Current use of any prescribed drug			73. Medical treatment in past 12 months		
66. Allergies or chemical sensitivities			74. CAT Scan, MRI or other special tests		
67. Allergic reactions that interfere w/ breathing			75. Smoked cigarettes or tobacco products		
68. Occupational (work) injuries			76. Any sleep disorder		
69. Disability or compensation claim			77. Heavy snoring		
70. Asbestos or toxic chemical exposures			78. Other health conditions		
71. Have you required light or restricted duty					

Please explain "yes" answers by referencing item number.

Provide (in the section to the right of each #) pertinent information relative to diagnosis and treatment for each "yes" response. Include dates for injuries, illnesses and follow up treatments. Please use the back of this page if necessary.

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

#_____ _____

Name: _____ Date of Birth: _____

PART II: RESPIRATORY SYSTEMS **Circle Yes or No**

1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month: Yes No
   If you smoked in the past, please list packs per day and number of years:
   ppd_____ ; years _____

2. Have you ***ever had*** any of the following conditions?
   a. Seizures (fits): Yes No
   b. Diabetes (sugar disease): Yes No
   c. Allergic reactions that interfere with your breathing: Yes No
   d. Claustrophobia (fear of closed-in places): Yes No
   e. Trouble smelling odors: Yes No

3. Have you ***ever had*** any of the following pulmonary or lung problems?
   a. Asbestosis: Yes No
   b. Asthma: Yes No
   c. Chronic bronchitis: Yes No
   d. Emphysema: Yes No
   e. Pneumonia: Yes No
   f. Tuberculosis: Yes No
   g. Cilicosis: Yes No
   h. Pneumothorax (collapsed lung): Yes No
   i. Lung cancer: Yes No
   j. Broken ribs: Yes No
   k. Any chest injuries or surgeries: Yes No
   l. Any other lung problem that you've been told about: Yes No

4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: Yes No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes No
   d. Have to stop for breath when walking at your own pace on level ground: Yes No
   e. Shortness of breath when washing or dressing yourself: Yes No
   f. Shortness of breath that interferes with your job: Yes No
   g. Coughing that produces phlegm (thick sputum): Yes No
   h. Coughing that wakes you early in the morning: Yes No
   i. Coughing that occurs mostly when you are lying down: Yes No
   j. Coughing up blood in the last month: Yes No
   k. Wheezing: Yes No
   l. Wheezing that interferes with your job: Yes No
   m. Chest pain when you breathe deeply: Yes No
   n. Any other symptoms that you think may be related to lung problems: Yes No

5. Have you ***ever had*** any of the following cardiovascular or heart problems?
   a. Heart attack: Yes No
   b. Stroke: Yes No
   c. Angina: Yes No
   d. Heart failure: Yes No
   e. Swelling in your legs or feet (not caused by walking): Yes No
   f. Heart arrhythmia (heart beating irregularly): Yes No
   g. High blood pressure: Yes No
   h. Any other heart problem that you've been told about: Yes No

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: Yes No
   b. Pain or tightness in your chest during physical activity: Yes No
   c. Pain or tightness in your chest that interferes with your job: Yes No

Name: _____ Date of Birth: _____

d. In the past two years, have you noticed your heart skipping or missing a beat: Yes No
e. Heartburn or indigestion that is not related to eating: Yes No
f. Any other symptoms that you think may be related to heart or circulation problems: Yes No

7. Do you ***currently*** take medication for any of the following problems?

a. Breathing or lung problems: Yes No
b. Heart trouble: Yes No
c. Blood pressure: Yes No
d. Seizures (fits): Yes No

8. If you've used a respirator, have you ***ever had*** any of the following problems?

a. Eye irritation: Yes No
b. Skin allergies or rashes: Yes No
c. Anxiety: Yes No
d. General weakness or fatigue: Yes No

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination.

_____ _____

Signature Date