



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.

PART I: Do you now have or have you ever had any of the following: (Check Yes or No)

	Yes	No		Yes	No
1. Fracture of skull, jaw or facial bones			33. Organ transplant		
2. Concussion or other injury to head			34. Liver, pancreas or gall bladder disease		
3. Thoracic outlet syndrome			35. Ulcer or bowel disease		
4. Fracture of neck, vertebrae or spine			36. Intestinal bleeding		
5. Recurrent back or neck pain			37. Hernia of any type		
6. Degenerated or herniated disc			38. Kidney or bladder disease		
7. Back injury or other abnormality			39. Abnormal balance or coordination		
8. Back, spine or neck surgery			40. Fainting, blackouts or dizzy spells		
9. Osteoporosis			41. Stroke, Aneurysm, or Bleeding in head		
10. Arthritis or joint injury or disease			42. Multiple sclerosis or muscular dystrophy		
11. Amputation involving hand or foot			43. Myasthenia gravis, ALS or Parkinson's Disease		
12. Carpal tunnel syndrome			44. Epilepsy or seizures		
13. Other hand or wrist problems			45. Dementia or memory loss		
14. Dislocation of any joint			46. Migraines or other severe headaches		
15. Injury or abnormality of arms or legs			47. Paralysis or muscle weakness		
16. Need for corrective lenses			48. Dyslexia or other neurological disorders		
17. Deficiency of color vision			49. Eczema or other skin disease		
18. Disease of the eyes or sinuses			50. Skin grafts		
19. Loss of hearing/hearing impairment			51. Bleeding disorder/anticoagulation		
20. Do you require any hearing accommodations, such as device or cell phone compatibility?			52. Sickle cell disease or trait		
21. Exposure to loud noise			53. Blood clots or thrombosis		
22. Disease of the ear or vertigo			54. High or low blood cell counts		
23. Deformity of mouth or jaw			55. Enlarged or ruptured spleen		
24. Speech impediment or disorder			56. Diabetes or high blood sugar		
25. Pneumothorax or collapsed lung			57. Thyroid or other endocrine disorder		
26. Lobectomy			58. Cancer, malignancy or tumor		
27. Bronchitis, asthma or other lung disease			59. PTSD, mental or other emotional disorder		
28. Abnormal electrocardiogram (EKG)			60. Mental health treatment of any type		
29. Heart disease or cardiac abnormality			61. Lupus, scleroderma, dermatomyositis		
30. Irregular heart rhythm			62. Heat stroke, frostbite or burns		
31. Angina/chest pain/shortness of breath			63. AIDS, HIV infection or hepatitis		
32. Hypertension/high blood pressure			64. Are you pregnant?		

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	Yes	No		Yes	No
65. Any history of alcohol or drug abuse			73. Military rejection or medical discharge		
66. Current use of any prescribed drug			74. Medical treatment in past 12 months		
67. Allergies or chemical sensitivities			75. CAT Scan, MRI or other special tests		
68. Allergic reactions that interfere w/ breathing			76. Smoked cigarettes or tobacco products		
69. Occupational (work) injuries			77. Any sleep disorder		
70. Disability or compensation claim			78. Heavy snoring		
71. Asbestos or toxic chemical exposures			79. Other health conditions		
72. Have you required light or restricted duty			80. Have you ever had any surgery or surgeries		

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.

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PART II: RESPIRATORY SYSTEMS

Circle Yes or No

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month:
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 |

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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 |
| 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 affirm that I am mentally and physically fit for duty.

I understand that inaccurate, false or missing information may invalidate the examination.

Signature

Date