



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 Yes or No)

	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. Bronchitis, asthma or other lung disease			57. Cancer, malignancy or tumor		
27. Abnormal electrocardiogram (EKG)			58. Mental or emotional disorder		
28. Heart disease or cardiac abnormality			59. Mental health treatment of any type		
29. Irregular heart rhythm			60. Lupus, scleroderma, dermatomyositis		
30. Angina/chest pain/shortness of breath			61. Heat stroke, frostbite or burns		
31. Hypertension/high blood pressure			62. AIDS, HIV infection or hepatitis		

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

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: 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? Yes No
- 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? Yes No
- 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? Yes No
- 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? Yes No
- 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? Yes No
- 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

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- 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