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 listed in the job description for an entry level Arizona peace officer. A medical examination, including this form, is required by the AZPOST prior to a peace officer appointment. This is to ensure each applicant is able to safely perform all essential functions with or without reasonable accommodation. Complete this form prior to your scheduled physical examination as directed by the hiring agency.

Name: ______________________________
Last, First, Middle

Address: ______________________________
Numbers, Street Name, City, State, & Zip Code

Date of Birth: ______________ Age: ____ Current Occupation: ______________
Month/Day/Year

Hiring Agency: ______________________________

SECTION A. For "YES" answers, list the question number and supply full details on the continuation sheet.

1. Medical Retired? Yes ☐ No ☐ From where? ______________
2. Prior Military? Yes ☐ No ☐ Branch? ______________
   - Job Title ______________
   - Out of US service? Yes ☐ No ☐ Where: ______________
3. Prior Law Enforcement? Yes ☐ No ☐ Where ______________

SECTION B. Have you ever had or do you now have any of the following? For "YES" answers, list the question number and supply full details on the continuation sheet of this form. If the condition required hospitalization, check the corresponding box in the "HOSPITAL" column.

CONDITION	YES	NO	HOSPITAL	CONDITION	YES	NO	HOSPITAL
1. Head Injury				7 Foot trouble or lameness.			
2. Back trouble or back pain				8.. Eye injury, surgery, or disease			
3. Any defects of bones or joints (including amputations, broken bones, dislocations)				9. Mental illness or nervous disorder			
4. Pernicious anemia or leukemia				10. Headaches			
5. Rheumatism or arthritis				11. Addiction to drugs or alcohol			
6. Trick or locked knee/knee injury				12. Hard of hearing or hearing problems			

Print Applicant's Name: ____

SECTION B - continued

CONDITION	YES	NO	HOSPITAL	CONDITION	YES	NO	HOSPITAL
13. Ever worn glasses or contact lenses				27. Polio			
14. Fainting, dizzy spells, or epilepsy				28. Rheumatic fever			
15. Hepatitis, jaundice, or liver aliment				29. Diabetes or sugar in urine			
16. Disorder of the nervous system				30. High or low blood pressure			
17. Tuberculosis or lung disease				31. Varicose veins			
18. Shortness of breath, asthma, or bronchitis				32. Heart trouble (including circulatory problems)			
19. Any type of blood disorder				33. Colitis			
20. Any sleeping problems				34. Gall bladder trouble			
21. Skin trouble				35. Kidney or bladder trouble			
22. Any complications from childhood diseases				36. Hemorrhoids or piles			
23. Sensitivity to dust				37. Rupture or hernia			
24. Other allergies				38. Mononucleosis			
25. Cancer or malignancy				39. Any contagious disease			
26. Tumor, growth or cyst				40. Any immune system disorder			

Question	Answer
41. Have you ever had or been advised to have an operation?	Yes ☐ No ☐
42. Have you ever been a patient (committed or voluntary) in a mental hospital?	Yes ☐ No ☐
43. Have you ever had any illness, injury or physical condition not named in this from, other than childhood diseases or minor illnesses?	Yes ☐ No ☐
44. Are you presently under a doctor's care for any condition?	Yes ☐ No ☐
45. Have you taken any medication during the last 12 months?	Yes ☐ No ☐
46 Have you taken any pain medication during the last 12months?	Yes ☐ No ☐
47. Do you smoke? If "YES", list the number and type of item(s) smoked Cigarettes: Individual ___________ | Packs ________ Cigars ________ Pipe _________ Other: Type ____________________________ Number per day ___________	Yes ☐ No ☐
48. Do you drink? If "YES", list the number of drinks per week ________	Yes ☐ No ☐

Print Applicant's Name: ______________________________

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

Date	Item	Physician	10 Digit Phone Number	Address (street, city, state zip)

SECTION C: PRESCRIBED MEDICATION: List all prescribed medication below. Use continuation page as necessary.

Name	Dosage	Frequency per day

SECTION D. ILLEGAL DRUGS OR CONTROLLED SUBSTANCES: List all illegal drugs or controlled substances you have ever used to alleviate 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. On the continuation page list the following for each drug(s) or controlled substances listed below:

- Was the use prescribed or recommended by a physician or health care provider? If yes, list the name address and 10-digit phone 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 the character of use; include methods of ingestion, location, dosages, frequencies, persons present or those persons with knowledge of the use.
- If applicable, describe why you stopped using the drug or controlled substance.
- 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.
- Describe any uses of the drug or controlled substances, other than to actually treat a medical condition.

I hereby authorize the above listed physician(s) to release any and all medical information to the hiring agency, AZPOST, 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 there are no willful misrepresentations, omissions or falsifications in the foregoing statements and answers to the questions and all statement 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 AZPOST may deem necessary.

______________________________ Signature of Applicant (Sign in Ink)

______________________________ Date

Print Applicant's Name: ____

CONTINUATION PAGE	
List the applicable **question number** for each entry made on this page. Use the space provided to complete answers for previously asked questions or for necessary explanations and clarification.	
Question Number	**Explanation** DIAGNOSIS, SYMPTOMS, DATE OF OCCURANCE, EXPLANATION, TREATMENT, MEDICATIONS, THERAPY, SURGERY, OUTCOME, LAST TREATMENT DATE