ANISHINABEK POLICE SERVICE

PRE-EMPLOYMENT VISION REPORT

APPLICANT NAME ______________________________

REACTION	ACCOM.	LIGHT
PUPILS	EQUAL	UNEQUAL
FUNDI		
FIELDS OF VISION		
COLOUR (TEST USED)		
WITHOUT GLASSES	NEAR	FAR
WITH GLASSES	RIGHT LEFT	RIGHT LEFT
	RIGHT LEFT	RIGHT LEFT

OTHER CONDITIONS OR COMMENTS

____

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PARTICULARS OF EXAMINER

NAME ______________________________

ADDRESS ______________________________

PHONE ______________________________

QUALIFICATIONS ______________________________

SIGNATURE ______________________________

ANISHINABEK POLICE SERVICE

HEALTH EXAMINATION REPORT

Position Applied For	Today Date Year _______ Month _______ Day_______
Sex ☐ Male ☐ Female	Date of Birth Year _______ Month _______ Day___
Surname	Given Names
Address City/Town	Postal Code Telephone
Family Doctor Address	Telephone

CONSENT

I, ________________________________, hereby consent to the release of the information gathered in respect of this medical examination to the Anishinabek Police Servcie to be used for the purpose of assisting in determining suitability for employment.

Date: ______________________

Witness: _________________________ Signature: ______________________

Personal History

Spouse

Children (Number and State of Health)

Military Services ☐ Yes ☐ No Disability Pension ☐ Yes ☐ No

Immunization

TB Skin		Date of Last Test	Result	Chest x-ray		Date of Last One	Reason
☐	Yes				☐ Yes		
☐	No				☐ No		

Past Health History

Past Illness (including Childhood Illnesses, High Blood Pressure, Heart Disease, Diabetes, Thyroid Disease, Cancer)

Operations

Accidents

Hospitalizations

Allergies

Medications (Prescription - Other)

Habits

	Yes	No	Quantity
Cigarettes - Tobacco			
Hard Drugs			
Alcohol			
Coffee/Tea			

Family History

	Mother	Father	Other		Mother	Father	Other		Mother	Father	Other
Tuberculosis				Epilepsy				Skin Disorder			
Diabetes				Blood Disorders				Kidney Diseases			
Cancer				Asthma				High Blood Pressure			
Nervous Disorders				Hay Fever				Heart Disease			
Glaucoma				Alcoholism							

Other Details : (include other Diseases)

PHYSICIAN'S EXAMINATION

SURNAME **GIVEN NAME** **DATE**

GENERAL	Appearance		
	Mental Status		
	Height		cm
	Weight	Usual	Present
	T.P.R.	T. P.	R.
EYES	Reaction	Accom.	Light
	Pupils	Equal	Unequal
	Fundi		
	Fields of Vision		
VISION	Color (Test Used)		
		Near	Far
	Without Glasses	R / L /	R / L /
	With Glasses	R / L /	R / L /
EARS	Hearing	R	L
	Drums	R	L
	Other	R	L
MOUTH TONGUE	Gums		
	Dental/Hygiene		
	Other		
THROAT-TONSILS			
NECK	Movement		
	Pain-Tenderness		
	Other		
THYROID			
LYMPH NODES			
BREASTS			
HEART	Size		
	Rhythm		
	Murmurs		
	Carolid Bruits		
BLOOD PRESSURE	Before Exercise		
EXCERISE AS APPROPRIATE (ESPECIALLY POLICE APPLICANTS)	Heart Rate Resting		
	After Exercise		
	1 Minuter After		
	2 Minutes After		
	Exercise (e.g. 20 step ups)	Time	EGG.
CHEST	Type		
	Resonance		
	Activenitious Sounds		
ABDOMEN	Appearance - Scars		
	Tenderness		
	Masses/Organs		
	Bowel Sounds		
HERNIA	Inguinal		
	Femoral		
	Other		
RECTAL			
HAEMMORHOIDS			
PROSTATE/PELVIC	If Appropriate		
DEFORMITIES			
EXTREMITIES	Arms/Hands		
	Legs/Feet		
	Varicose Veins	R	L
JOINTS	Upper (Espec. Shoulders)		
	Lower (Espec. Knees)		
SKIN			
SPINE	Mobility		
	Pain/Tenagmes		
	Deformity		
NERVOUS SYSTEM	General		
	Tendon Reflexes	R	L

LABORATORY	Haemoglobin	
	Urine (Dip Stick)	Alb. Sugar
	Other Tests If Indicated	
CHEST X-RAY	Date	

Pulmonary Function Tests (if indicated) Date

ECG (if appropriate)

Health Education (Specify)

Immunization Given (Specify)

THIS SPACE FOR ADDITIONAL INFORMATION AND REMARKS

Impressions Healthy ☐ Health Problems ☐

Fit For Job ☐ Fit with limitations ☐ Unfit ☐

Please describe problems/limitations

Examining Physician (Please Print Name)

Phone

Address

SIGNATURE

Health History (Continued) Functional Enquiry

A. Current Health Status ☐ Good or ☐ Bad

B. Are you suffering from or under treatment for any disease now? ☐ Yes ☐ No Name ______________________

C. Do you have a pre-existing illness or injury that would prevent you from doing the essential duties of the job?

☐ Yes

☐ No

D. Do you now or have you ever suffered from any of the following

	Yes	No		Yes	No		Yes	No
Recent Change in Weight			Allergy to Drugs			Constipation - Diarrhea		
Recent Fatigue or Weakness			Anemia - Blood Conditions			Bloody or Black Bowel Movement		
Head Injury or Concussion			Breast Problems - Lumps			Haemorrhoids		
Fainting Spells or Dizziness			Night Sweats			Hernia or Rupture		
Epilepsy or Convulsions			Chronic Cough			Kidney or Bladder Trouble		
Frequent Headaches			Coughing - Mucus or Blood			Infections, or Stones		
Migraine			Lung Disease i.e.. TB, Pneumonia			Frequently Passing Water		
Ear Aches or Infections			Bronchitis, Emphysema			Pain - Burning Discharge		
Ear Noises or Deafness			Shortness of Breath			Urine - Bloody or Discolored		
Eye Irritation or Infection			Palpitations			Neck or Back injury or Pain		
Serious Eye Problems			Heart Trouble			Low Back Pain		
Vision Problems			Chest Pain - Pressure - Tightness			Varicose Veins - Phlebitis		
Nose or Throat Problems			Swelling of the Ankles			Numbness or Tingling		
Frequent Nose Bleeds			Rheumatic or Scarlet Fever			Rheumatism or Arthritis		
Sinus Trouble			Ulcers - Stomach Trouble			Other Joint or Muscle Problems		
Frequent Colds/Sore Throats			Indigestion - Nausea - Vomiting			Foot Problems		
Tooth or Gum Trouble			Vomiting Blood			Problems Sleeping		
Skin Rashes; Itchiness, Burning			Liver Trouble - Jaundice			Nervous Trouble Breakdowns		
Skin - Moles - Tumor			Abdominal Pain			Menstrual Problems		
Hives - Hay Fever Asthma			Bowel Trouble			Have You Any Restriction on Physical Activity		

Explain "yes" answers

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