Medical Assessment Tools

Record of Medical History for Selection as a Police Constable

(*To be completed by the applicant*)

NAME:	ADDRESS:
ID#: AGE:	
TELEPHONE#:	
TODAY'S DATE:	POSTAL CODE:

NOTE: *Applicants are responsible for ensuring that they understand the questions below. Applicants are advised to consult with a family physician to gain clarity and/or review the completed responses, if required. Untruthful or misleading information may in employment disqualification or dismissal, if already hired.*

Have you ever been diagnosed with, or undergone treatment for, illnesses, diseases or conditions associated with:
(Circle YES or NO)

1. Labyrinthitis, glaucoma or other condition of the eyes, ears, nose or throat?

   YES or NO

2. Refractive surgery of any type (including intra-ocular lenses, phakic intraocular lens implants or implantable contact lenses), non-surgical reshaping of the eye (orthokeratology) or corneal transplant?

   YES or NO

3. Infection with or past exposure to tuberculosis, pleurisy, asthma, chronic bronchitis, pulmonary fibrosis, pulmonary embolus, pneumonia, previous intubation or any condition afflicting the respiratory system?

   YES or NO

Note: If response is positive for tuberculosis, examining physician to refer to Appendix 7 for more information

4. Hypertension (elevated blood pressure), circulation disorder, deep vein thrombosis, infection involving the heart, heart murmur, heart valve irregularity, heart attack, angina, coronary disease, heart failure, irregular electrocardiogram (ECG), or other condition afflicting the cardiovascular system?

   YES or NO

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5. Peptic ulcer, gastrointestinal bleeding inflammatory bowel disease, hernia, disease or inflammation of the oesophagus, stomach, liver, gallbladder, pancreas, small intestine, colon or any other condition afflicting the gastrointestinal (digestive) system?

YES or NO

6. Nephritis, documented blood, protein or glucose in your urine, disease or inflammation of the kidney, kidney stones, bladder, prostate or any other condition afflicting the urinary system?

YES or NO

7. Epilepsy, seizures, multiple sclerosis, Tourette Syndrome, cerebral palsy, muscular dystrophy, Parkinson's disease, poliomyelitis, spina bifida, damage to a nerve or the nervous system, head injury, neurological deficit or any other condition afflicting the nervous system?

YES or NO

Note: If response is positive, examining physician to refer to Appendix 5 for more information.

8. Diabetes, thyroid disorder or any other condition of the endocrine system?

YES or NO

Note: If response is positive, examining physician to refer to Appendix 6 for more information

9. Rheumatism, arthritis, gout disc disease, chronic back pain, arthroplasty, trauma or any other condition afflicting the back or other areas of the musculoskeletal system?

YES or NO

10. Disease or condition afflicting the skin?

YES or NO

11. Bleeding disorder, anemia, immune deficiency, blood product deficiency/abnormality, hypercoaguable state or any other condition of the blood system?

YES or NO

12. Infection with or past exposure to hepatitis virus (A, B or C)?

YES or NO

13. Infection with or past exposure to human immunodeficiency virus (HIV) or any other ongoing infection?

YES or NO

Note: If response is positive, examining physician to refer to Appendix 7 for more information.

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14. Cancer of any kind?

YES or NO

15. Depression, mania, schizophrenia, panic attacks or any other conditions afflicting your mental health?

YES or NO

16. Attention Deficit Hyperactivity Disorder, obsessive/compulsive disorder or anger management problems?

YES or NO

17. Have you ever been diagnosed with a congenital abnormality?

YES or NO

Do you currently, or have you ever, experienced any of the following:

1. Shortness of breath, wheezing, chronic cough, cough producing blood or change in voice?

YES or NO

2. Palpitations (*awareness of an irregularity in your heart beat*), dizziness, fainting or near fainting, swelling of the ankles, shortness of breath with minimal exercise or lying down flat, any sense of pain, pressure or tightness in the chest, neck or arms?

YES or NO

3. Difficulty swallowing, sores or pain in mouth, change in bowl habits, blood in your stools, jaundice or a significant period of diarrhea, nausea, vomiting, or abdominal pain?

YES or NO

4. Incontinence, difficulty urinating, pain or discharge from the genitals, change in the colour or your urine?

YES or NO

5. Tremor or shakiness, memory loss, headaches, decreased balance or co-ordination, decreased hearing, vision, taste or smell, decreased strength, decreased sensation or tingling in the hands or feet?

YES or NO

6. Decreased range of motion in your neck or other major joints, joint pain, stiffness or swelling?

YES or NO

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7. Area or mark on the skin that has changed in colour or size, persistent sores, undiagnosed skin irregularities or bumps?
   YES or NO

8. Periods of feeling depressed, helpless, worthless or suicidal?
   YES or NO

9. Feelings of unprovoked anxiety, panic, accelerated heart rate or dizziness?
   YES or NO

10. Difficulty sleeping, fatigue, weight change of more than 15 pounds or 7 kilograms in the last six months?
    YES or NO

11. Repetitive, forceful and involuntary movements of parts of your body?
    YES or NO

Have you ever:

1. Been physiologically or psychologically dependent on drugs or alcohol?
   YES or NO
2. Had anyone express concern about your alcohol consumption?
   YES or NO
3. Felt badly or guilty about your drinking or felt you should drink less?
   YES or NO
4. Had an alcoholic drink first thing to steady your nerves or get rid of a hangover?
   YES or NO

Note: If response is positive for any of the four questions above, examining physician to refer to Appendix 8 for more information.

Please list any:

1. Medications you have taken in the last year____
   ____
2. Allergies and associate reactions____
   ____
3. Operations you have had (e.g. laser eye surgery, coronary bypass surgery, appendectomy, etc.) and the year they were performed:____
   ____
   ____

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Please answer the following questions:

1. Do your parents, grandparents, siblings or children have a history of: Cancer, diabetes, coronary artery disease, multiple sclerosis, hypertension or mental illness? If yes, please indicate.________
   ____
   ____
2. Do you smoke or did you smoke previously? If yes, please indicate frequency and duration. ____
   ____
3. Do you have and other medical, psychological or physical disorder that was not identified above?
   ____

It is important that you consider carefully all answers to the questions above before signing the following declaration. Remember that untruthful or misleading responses may result in employment disqualification or dismissal, if already hired.

I, THE UNDERSIGNED, DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE FULL, COMPLETE AND TRUE, AND ARE CORRECTLY RECORDED.

_________________________________ _________________________________

Signature of Applicant *Signature of Witness to the Applicant's Signature*

Dated this ________day of ________________20____

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Record of Medical Examination for Selection as a PoliceConstable
(To be completed by a nurse practioner or physician)

Name of Applicant: ___________________________________ ID #:________________

Height: ____________cm **Weight: ___________**kg **Gender: M or F**

General Appearance (jaundice, pallor, fatigue, alert, etc.):____________________________

Comments:

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Head, Ears, Eyes, Nose & Throat	Normal		Notable Findings *
	R	L	
Pupil & Conjunctiva			
Extraocular Movements			
Fundiscopic Evaluation			
Visual Acuity (uncorrected)	20/	20/	
Visual Acuity (corrected)	20/	20/	
Colour Vision (uncorrected)	Normal	Abnormal	
Tympanic Membrane			
Nasal Septum			
Oropharynx			
Thyroid			
Cervical Adenopathy			
Pulmonary System	Normal		Notable Findings*
Inspection			
Palpation			
Percussion			
Auscultation			
Cardiovascular System	Normal		Notable Findings*
Heart Rate _____bpm; Regular/Irregular			
Blood Pressure:	Left: Right:		
Inspection			
Palpation			
Auscultation			
Abdomen	Normal		Notable Findings*
Inspection			
Palpation			
Percussion			
Auscultation			

* check list of medical conditions that require follow up and may result in failure

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Cutaneous	Normal		Notable Findings*
Skin			
Musculoskeletal	Normal		
	R	L	
Upper Extremities:			
Strength			
Movement			
Joints			
Lower Extremities:			
Strength			
Movement			
Joints			
Back:			
Strength			
Flexibility			
Nervous System	Normal		Notable Findings*
Cranial Nerves II-XII			
Tremor			
Gait			
Reflexes			
Urinalysis	Normal		Notable Findings*
Blood			
Protein			
Glucose			
Ketones			
Hematology (if clinically indicated)	Normal		Notable Findings*
Other Laboratory Testing (if clinically indicated)	Normal		Notable Findings*

* check list of medical conditions that require follow up and may result in failure

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Having given due consideration to the information contained in the Record of Medical History and Record of Medical Examination, I am of the opinion that the Applicant is _____ / is not_____ medically capable of performing the duties of a front line Police Constable. Therefore, I do ____ / do not____ unhesitatingly recommend the acceptance of the Application for employment in that capacity.

If opinion is negative, provide reason(s):____
____
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____

Name of Medical Examiner (Please Print): ____

Dated this ________ day of _____________ 20______

____
SIGNATURE OF MEDICAL EXAMINER

Medical Assessment Tools

Summary Result of the Medical Evaluation

The information contained in this form will be retained in the confidence by the hiring police services. The Record of Medical History and the Record of Medical Examination will be retained by the medical examiner.

APPLICANT'S RELEASE OF MEDICAL INFORMATION

Having been duly informed, I, the undersigned, direct the information determined in this medical examination to be provided to the **HIRING POLICE SERVICE** for consideration in the evaluation of my application for the employment as a police constable.

Name of Applicant (Please Print):

*Signature of Applicant*____

*Dated this*________________ *day of* ________________ *20*_______

STATEMENT OF THE MEDICAL EXAMINER

Having given due consideration to the information in the Record of Medical History and Record of Medical Examination of _______________________________(*name of applicant)*, and in consideration of the "Guidelines for Examining Physicians Medical Evaluation of Police Constable Applicants," I am___ / am not ___ of the opinion that the applicant is medically capable of performing the duties of a front line Police Constable and I recommend the acceptance _____ / disqualification ____ of the applicant for employment in that capacity.

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*Name of Medical Examiner (Please Print):*____

Signature of Medical Examiner: ____

Dated this _______________________ *day of* ________________________ *20*____________