

MEDICAL QUESTIONNAIRE AND EXAMINATION CHECKLIST

This checklist will assist in ensuring that all required information needed for employment physicals is provided by the Member and the Licensed Physician to the LOPFI-covered employer.

Applicant Name: _____ **Last 4 of SS#** _____

APPLICANT COMPLETES

- ☐ Properly complete the Medical History Questionnaire
- ☐ Provide properly completed Medical History Questionnaire to the examining physician
- ☐ Provide a copy of the Job Description and Duties to the examining physician
- ☐ Provide Medical Examination Report to the examining physician

(By providing your signature you certify that the information on all forms listed above is true and correct.)

Applicants Printed Name

Applicants Signature

Date

PHYSICIAN COMPLETES

- ☐ Review completed Medical Questionnaire provided by applicant
- ☐ Review Job Description and Duties provided by applicant
- ☐ Properly complete the Medical Examination Report

(By providing your signature below you certify that you have reviewed the job description and the Medical Questionnaire and properly completed the Medical Examination Report.)

Physician's Printed Name

Signature

Date

EMPLOYER COMPLETES

- ☐ Review completed Medical Questionnaire
Any notable conditions/concerns? ☐ No ☐ Yes _____
- ☐ Review Medical Examination Report
Any notable conditions/concerns? ☐ No ☐ Yes _____

(By providing your signature below you certify that you have received the completed Medical Questionnaire and Medical Examination Report and shall retain all documents in applicant's file.)

Employer Representative Printed Name

Signature

Date

This checklist was designed as an aid with pre-employment physicals for applicants seeking employment with a LOPFI-covered employer. Please contact the employer directly with any questions regarding your pre-employment physical.

MEDICAL QUESTIONNAIRE

Instructions to applicants: Complete this form prior to your physical examination and give to the examining physician along with a copy of the Job Description for the LOPFI-covered position you have applied.

Applicant's Name (Last, First, Middle)

Last 4 of SSN

Address

Date of Birth

Age

Current Occupation

SECTION A: HAVE YOU EVER OR DO YOU NOW HAVE ANY OF THE FOLLOWING? FOR "YES" ANSWERS, SUPPLY FULL DETAILS ON RIGHT SIDE OF PAGE OR SECTION B.

General:

- | | | | |
|---|------------------------------|-----------------------------|-------|
| 1. Decreased exercise tolerance? | ☐ YES | ☐ NO | _____ |
| 2. Fatigue? | ☐ YES | ☐ NO | _____ |
| 3. Weight change? (plus/minus 10 lbs) | ☐ YES | ☐ NO | _____ |
| ☐ Gain ☐ Loss | ☐ YES | ☐ NO | _____ |
| 4. Change in Appetite? | ☐ YES | ☐ NO | _____ |

Integumentary (Skin):

- | | | | |
|--------------------------------|------------------------------|-----------------------------|-------|
| 5. Changes in moles? | ☐ YES | ☐ NO | _____ |
| 6. Rash? | ☐ YES | ☐ NO | _____ |
| 7. Changes in skin/hair/nails? | ☐ YES | ☐ NO | _____ |
| 8. Ulcers/Sores? | ☐ YES | ☐ NO | _____ |

Eyes:

- | | | | |
|---|------------------------------|-----------------------------|-------|
| 9. Do you wear glasses/contact lenses? | ☐ YES | ☐ NO | _____ |
| 10. Do you have blurred vision? | ☐ YES | ☐ NO | _____ |
| 11. Flashes of light? | ☐ YES | ☐ NO | _____ |
| 12. Vision halos? | ☐ YES | ☐ NO | _____ |
| 13. Do you have a history of cataracts? | ☐ YES | ☐ NO | _____ |
| 14. Glaucoma? | ☐ YES | ☐ NO | _____ |
| 15. Blindness? | ☐ YES | ☐ NO | _____ |
| ☐ Right eye? ☐ Left eye? ☐ Both? | | | |

Ear, Nose, Mouth and Throat:

- | | | | |
|---|------------------------------|-----------------------------|-------|
| 16. Do you have any hearing loss? | ☐ YES | ☐ NO | _____ |
| ☐ Right ear? ☐ Left ear? ☐ Both? | | | |
| 17. Hearing aid? | ☐ YES | ☐ NO | _____ |
| 18. Do you wear dentures/braces? | ☐ YES | ☐ NO | _____ |
| 19. Teeth problems? | ☐ YES | ☐ NO | _____ |
| 20. Chronic sinus problems? | ☐ YES | ☐ NO | _____ |
| ☐ Pain? ☐ Congestion? | | | |
| 21. Do you have frequent nose bleeds? | ☐ YES | ☐ NO | _____ |
| 22. Deviated septum? | ☐ YES | ☐ NO | _____ |
| 23. Hoarseness/Changes in voice? | ☐ YES | ☐ NO | _____ |
| 24. Sore throat? | ☐ YES | ☐ NO | _____ |
| 25. Bleeding gums? | ☐ YES | ☐ NO | _____ |
| 26. Trouble swallowing? | ☐ YES | ☐ NO | _____ |
| 27. Lump/masses? | ☐ YES | ☐ NO | _____ |

Respiratory:

- | | | | |
|---|------------------------------|-----------------------------|-------|
| 28. Do you wheeze? | ☐ YES | ☐ NO | _____ |
| 29. Do you have a chronic cough? | ☐ YES | ☐ NO | _____ |
| 30. Have you coughed up blood? | ☐ YES | ☐ NO | _____ |
| 31. Do you experience shortness of breath? | ☐ YES | ☐ NO | _____ |
| ☐ At rest? ☐ With activity? | | | |
| 32. Do you snore? | ☐ YES | ☐ NO | _____ |
| 33. COPD? | ☐ YES | ☐ NO | _____ |
| 34. Pneumonia? | ☐ YES | ☐ NO | _____ |
| 35. Asthma? | ☐ YES | ☐ NO | _____ |
| 36. Lung disease? | ☐ YES | ☐ NO | _____ |

Cardiovascular:

37. Chest pain, pressure or tightness? ☐ YES ☐ NO _____
☐ At rest? ☐ With activity?
38. Heart palpitations (racing)? ☐ YES ☐ NO _____
39. Irregular heartbeats? ☐ YES ☐ NO _____
40. Short of breath lying flat? ☐ YES ☐ NO _____
41. Have you passed out? ☐ YES ☐ NO _____
42. Swelling of feet or ankles? ☐ YES ☐ NO _____
43. Pain in legs with walking? ☐ YES ☐ NO _____
44. Heart failure? ☐ YES ☐ NO _____
45. Heart attack? ☐ YES ☐ NO _____
46. Cardiac arrhythmia? ☐ YES ☐ NO _____
47. Heart murmur or prolapse? ☐ YES ☐ NO _____
48. Blood pressure problems? ☐ High? ☐ Low? ☐ YES ☐ NO _____
49. Stroke? ☐ YES ☐ NO _____
50. Fainting spells? ☐ YES ☐ NO _____

Gastrointestinal System:

51. Frequent nausea and/or vomiting? ☐ YES ☐ NO _____
52. Abdominal pain? ☐ YES ☐ NO _____
53. Black, tarry stool? ☐ YES ☐ NO _____
54. Bright red blood in stool? ☐ YES ☐ NO _____
55. History of stomach ulcers? ☐ YES ☐ NO _____
56. Frequent diarrhea? ☐ YES ☐ NO _____
57. History of gallbladder problems? ☐ YES ☐ NO _____
58. History of liver problems? ☐ YES ☐ NO _____

Genitourinary:

59. Do you have pain with urination? ☐ YES ☐ NO _____
60. Sense of urgency to urinate? ☐ YES ☐ NO _____
61. Awaken frequently to urinate? ☐ YES ☐ NO _____
62. History of bladder, kidney infection? ☐ YES ☐ NO _____
63. History of kidney stones? ☐ YES ☐ NO _____
64. Males: Prostate problems? ☐ YES ☐ NO _____
65. Females: Post menopausal? ☐ YES ☐ NO _____
66. Currently taking hormone replacement? ☐ YES ☐ NO _____

Musculoskeletal:

67. Chronic back pain? ☐ YES ☐ NO _____
68. Arthritis? ☐ YES ☐ NO _____
69. History of gout? ☐ YES ☐ NO _____
70. Joint pain or stiffness? ☐ YES ☐ NO _____
71. Limited joint movement? ☐ YES ☐ NO _____
72. Muscle pain or cramps? ☐ YES ☐ NO _____
73. Muscle weakness? ☐ YES ☐ NO _____
74. History of blood clots in legs? ☐ YES ☐ NO _____
75. History of varicose veins? ☐ YES ☐ NO _____

Neurological:

76. Temporary blurred vision/loss of vision? ☐ YES ☐ NO _____
77. Temporary weakness, numbness and/or tingling ☐ YES ☐ NO _____
involving an arm or leg?
78. Severe headaches? ☐ YES ☐ NO _____
79. Migraine headaches? ☐ YES ☐ NO _____
80. Convulsions/Seizures? ☐ YES ☐ NO _____
81. Epilepsy? ☐ YES ☐ NO _____
82. Tremors? ☐ YES ☐ NO _____

Endocrine:

83. High cholesterol? ☐ YES ☐ NO _____
84. Diabetes? ☐ YES ☐ NO _____
85. Thyroid problems? ☐ YES ☐ NO _____

Hematological/Immunologic:

- | | | | |
|-------------------------------------|------------------------------|-----------------------------|-------|
| 86. Chronic low blood count/anemia? | ☐ YES | ☐ NO | _____ |
| 87. Bleeding problems? | ☐ YES | ☐ NO | _____ |
| 88. Allergies? | ☐ YES | ☐ NO | _____ |
| 89. Blood Disease (Leukemia)? | ☐ YES | ☐ NO | _____ |
| 90. Blood Clots/DVT? | ☐ YES | ☐ NO | _____ |
| 91. Tuberculosis? | ☐ YES | ☐ NO | _____ |
| 92. Hepatitis? | ☐ YES | ☐ NO | _____ |
| 93. Cancer? | ☐ YES | ☐ NO | _____ |
| 94. Lupus? | ☐ YES | ☐ NO | _____ |
| 95. Steroid Medications? | ☐ YES | ☐ NO | _____ |

Psychiatric:

- | | | | |
|--|------------------------------|-----------------------------|-------|
| 96. History of depression? | ☐ YES | ☐ NO | _____ |
| 97. Anxiety? | ☐ YES | ☐ NO | _____ |
| 98. Panic attacks? | ☐ YES | ☐ NO | _____ |
| 99. History of drug or alcohol abuse? | ☐ YES | ☐ NO | _____ |
| 100. Trouble sleeping? | ☐ YES | ☐ NO | _____ |
| 101. Thoughts of suicide? | ☐ YES | ☐ NO | _____ |
| 102. Decreased appetite? | ☐ YES | ☐ NO | _____ |
| 103. Increased appetite? | ☐ YES | ☐ NO | _____ |
| 104. Eating disorder? | ☐ YES | ☐ NO | _____ |
| 105. Loss of sense of humor? | ☐ YES | ☐ NO | _____ |
| 106. Less ability to enjoy regular activities? | ☐ YES | ☐ NO | _____ |
| 107. Tearfulness? | ☐ YES | ☐ NO | _____ |
| 108. Lack of concentration? | ☐ YES | ☐ NO | _____ |
| 109. Irritability? | ☐ YES | ☐ NO | _____ |
| 110. Loss of energy? | ☐ YES | ☐ NO | _____ |
| 111. Lowered self esteem? | ☐ YES | ☐ NO | _____ |
| 112. Less interest in daily grooming?
(bathing, shaving, wash hair, etc.) | ☐ YES | ☐ NO | _____ |
| 113. Mania? | ☐ YES | ☐ NO | _____ |
| 114. Hearing voices? | ☐ YES | ☐ NO | _____ |
| 115. Obsessive thoughts? | ☐ YES | ☐ NO | _____ |
| 116. Compulsive behavior? | ☐ YES | ☐ NO | _____ |

PSYCHIATRIC HISTORY

Are any of the following areas of your life particularly stressful to you? (Check all that apply)

- | | | | |
|--|--|---|-------------------------------------|
| ☐ Marriage/relationship | ☐ Health | ☐ Legal problems | ☐ Employment |
| ☐ Financial problems | ☐ Family problems | ☐ Sexual issues | ☐ Violence |

Please explain:Have you ever been treated for a psychiatric illness (depression, anxiety, bipolar, etc.?) ☐ YES ☐ NOHave you ever been treated in a psychiatric facility? ☐ YES ☐ NO*If yes to either of the above questions, please list doctor's names, hospitals, and dates of treatment:*

Have you had any of the following?

- | | | |
|-------------------|------------------------------|-----------------------------|
| Neurological Exam | ☐ YES | ☐ NO |
| Psychiatric Exam | ☐ YES | ☐ NO |

Psychological Testing	☐ YES	☐ NO
Professional counseling/psychotherapy	☐ YES	☐ NO
<i>If you answered YES to any of the above, please list the names of the doctor or therapist and dates seen:</i>		

Other medical history not listed above:

PREVIOUS SURGERY (PLEASE LIST ALL SURGERIES. ATTACH ADDITIONAL PAGE(S) IF NEEDED)				
Procedure	Date	Hospital	Surgeon	Complications

SECTION B	WRITE YOUR OWN ACCOUNT AND EXPLAIN ALL ITEMS ANSWERED "YES" IN THE QUESTIONNAIRE; IDENTIFY ITEM NUMBER, INCLUDE DIAGNOSIS, DATE OF ONSET, AND YOUR PRESENT CONDITION, CONTINUE ON ADDITIONAL PAGE(S) IF NEEDED.

PENALTY

ANY FALSIFICATION, WITHHOLDING OR FAILURE TO ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY MAY CAUSE FORFEITURE OF ALL RIGHTS TO THIS EMPLOYMENT AND/OR LOPFI RETIREMENT BENEFITS.

CERTIFICATION

I HEREBY CERTIFY THAT THERE ARE NO WILLFUL MISREPRESENTATIONS, OMISSIONS OR FALSIFICATIONS IN THE FOREGOING STATEMENTS AND ANSWERS, AND THAT ALL RESPONSES ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF APPLICANT	DATE SIGNED:
(SIGN IN INK) X_____	

MEDICAL EXAMINATION REPORT

To Be Completed by a Licensed Physician

INSTRUCTIONS TO EXAMINING PHYSICIAN: Please review Medical Questionnaire before examining the candidate.

1. Name (Last, First, Middle)		2. Last 4 of SSN		3. Birth Date (Mo., Day, Yr.)					
4. Height (without shoes)		5. Weight (without shoes)		6. Chest Girth (Expiration)		7. Abdomen Girth			
8. Visual Acuity (If applicant wears corrective lenses, test and record acuity both with and without corrective lenses.)									
a. Color discrimination				b. Depth Perception					
c. Peripheral Vision (temporal) Right Eye degrees				Left Eye degrees					
(Each eye on zero line.)									
d. Visual Acuity (16 inches) without glasses		R-20/		L-20/		B-20/			
(16 inches) with glasses		R-20/		L-20/		B-20/			
(20 feet) without glasses		R-20/		L-20/		B-20/			
(20 feet) with glasses		R-20/		L-20/		B-20/			
e. Does examination reveal any internal or external eye pathology? ☐ No ☐ Yes									
If yes, describe:									
f. Is there any apparent eye deviation? ☐ No ☐ Yes									
Note any eye or visual abnormality.									
9. HEARING									
RIGHT 15/		HEARING AID USED			DRUM PERFORATION OR DRAINAGE				
LEFT 15/		☐ NO ☐ YES			☐ NO ☐ YES				
NOTE ANY ABNORMALITY									
10. Head (note any defect, disease, or injury involving eyes, ears, nose, mouth, throat)						11. Dentistry Recommended			
						☐ NO ☐ YES			
12. Lungs			13. Date Chest X-ray Taken			14. Chest X-ray normal			
						☐ NO ☐ YES			
15. CARDIOVASCULAR SYSTEM									
TYPE OF ACTION		BLOOD PRESSURE		PULSE RATE		SOUNDS		RHYTHM	
A. AT REST									
B. AFTER MODERATE EXERCISE									
C. TWO MINUTES AFTER EXERCISE									
D. CIRCULATION TO EXTREMITIES				E. NOTE ANY ABNORMALITY					
16. NERVOUS SYSTEM (describe any pathology or abnormal reflexes)									
17. ABDOMEN				18. RECTAL					
MASSES				FISSURE					
TENDERNESS				FISTULA					
HERNIA				HEMORRHOIDS					
19. GENITO-URINARY SYSTEM (note any abnormalities)									

20. MUSCULO - SKELETAL (Test by bending, stooping, squatting also by head, arm, leg, and finger motions)				
A. SPINE	MOBILITY	SYMMETRY	POSTURE	X-RAY RECOMMENDED ☐ NO ☐ YES
B. UPPER EXTREMITIES	LIMITED FUNCTION		MISSING PARTS	
C. LOWER EXTREMITIES	LIMITED FUNCTION		MISSING PARTS	
21. SKIN (scars, varicosities, disease, abnormalities - nature and severity)				
22. LABORATORY (Report May Be Attached)				
A. URINALYSIS	SP. GRAVITY	ALB.	SUGAR	MICROSCOPIC
B. SEROLOGY (VORL) ☐ POSITIVE ☐ NEGATIVE ☐ NON-REACTIVE BLOOD TYPE _____				
23. ARE THERE ANY CONDITIONS, PHYSICAL, MENTAL OR EMOTIONAL WHICH, IN YOUR OPINION, SUGGEST FURTHER EXAMINATION? ☐ NO ☐ YES (explain in 26 below)		24. DO YOU HAVE ANY RESERVATIONS ABOUT THIS CANDIDATE'S ABILITY TO PERFORM THE DUTIES OF A LOPFI-COVERED POLICE OFFICER OR FIREFIGHTER? ☐ NO ☐ YES (explain in 26 below)		
25. ANY NOTABLE CONDITIONS OR CONCERNS ☐ NO ☐ YES (explain in 26 below)				
26. EXPLANATION/COMMENTS				
PHYSICIAN'S SIGNATURE			NAME AND ADDRESS OF PHYSICIAN (Print or Type)	
DATE				