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 Questionnaire*
- ☐ Provide completed *Medical Questionnaire* to the licensed physician
- ☐ Provide a copy of the Job Description and Duties to the licensed physician
- ☐ Provide *Medical Examination Report* to the licensed physician

(By providing your signature below you certify that the information on the *Medical Questionnaire* is true and correct.)

_________________________ ___________________________________ ____________

Applicants Printed Name | 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 involving an arm or leg? ☐ YES ☐ NO ________
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 ________

Applicant's Name

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 ☐ NO

Have 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

Applicant's Name

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

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 (SIGN IN INK) X______________________________	DATE SIGNED:

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/__________ LEFT 15/__________	**HEARING AID USED** ☐ NO ☐ YES	**DRUM PERFORATION OR DRAINAGE** ☐ 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	