POLICE OFFICER TRAINING PROGRAM

MERCED COMMUNITY COLLEGE

HEALTH HISTORY AND PHYSICAL EXAMINATION

NOTE: Fill out history portion before visiting your physician

NAME: _____ _____ _____
Last First Middle Sex Today's Date

ADDRESS: _____
Number Street City Zip

PHONE: __(___)_____ Height _____ Weight: ____ Age: _____
Area Number Inches Lbs.

BIRTH DATE: _____ STUDENT I.D. NUMBER _____

DIRECTIONS: Please fill out this form as completely as possible. If you have any questions, DO NOT GUESS. Ask your physician for assistance.

I. Personal Health History and Risk Factors

Give the date, address, and physician who gave your last physical examination.
_____
_____

Characterize your present health status (check one)

Excellent _____ Good _____ Fair _____ Poor _____

A. Cardiovascular Health: Have you ever had:
Rheumatic Fever _____ Diabetes _____
Heart Murmur _____ Dizziness/Fainting Spells _____

Answer the following questions YES or NO

_____ Has a doctor said that your blood pressure was too high or too low?
_____ Do you ever have pain in your heart or chest?
_____ Are you often bothered by a thumping or racing of the heart?
_____ Do you ever notice skipping of your heartbeat?
_____ Are you ankles ever badly swollen?
_____ Has a doctor ever said you had or have heart trouble?
_____ Do you suffer from frequent cramps in your legs?
_____ Do you often have difficulty breathing?
_____ Do you get out of breath long before anyone else?
_____ Do you sometimes get out of breath when sitting still or sleeping?

B. General Health

Have you ever had:

_____ Polio
_____ Asthma or lung disease
_____ Injuries to back, arms, legs or joints
_____ Scarlet Fever
_____ Meningitis or Encephalitis
_____ pneumonia
_____ Pleurisy
_____ Hepatitis (jaundice)
_____ Tuberculosis
_____ Theumatoid Arthritis
_____ Kidney Disease
_____ Chronic Intestinal Disease
_____ Allergic Disease

List Surgical Procedures: _____
List Major Injuries: _____
List Unconsciousness for any reason: _____

Do you now have or have you recently had:

_____ Any significant vision or hearing problems?
_____ A history or anemia or bleeding tendency, or poor healing of cuts or wounds?
_____ A chronic, recurrent or morning cough?
_____ Any episode of coughing up blood?
_____ Swollen, stiff on painful joints?
_____ Pain in your legs after walking short distances?
_____ Back pain?
_____ Numbness in arm or leg?
_____ Nausea?
_____ Bowel or kidney/urine problems?
_____ Stomach or intestinal problems?
_____ Migraine or recurrent headaches?
_____ Frequent colds or sore throats?
_____ Skin problems?
_____ Increased anxiety or depression?
_____ Problems with recurrent fatigue, trouble sleeping or increased irritability.
_____ Are you taking any prescribed medications?
List:_____
_____ Do you take any self-prescribed medications or dietary supplements?
List:_____
_____ Do you have dentures or any removable dental fixtures?
Describe: _____

THE FOLLOWING ARE QUESTIONS FOR WOMEN ONLY:

Pregnancies? _____ If yes, number: _____
Deliveries? _____ If yes, number: _____
Miscarriages? _____ I yes, number: _____
Gynecological disease and disorders? _____
If yes, specify: _____

C. HEART DISEASE RISK FACTORS

1. Family History:

Have any of your immediate blood relations had any of the following: (Include parents, siblings, aunts, uncles, and grandparents: exclude cousins and half relations.)

_____ Heart attaches or strokes under the age of 60.
_____ High blood pressure
_____ Heart operations
_____ Diabetes

2. Smoking and Alcohol:

Describe your present and past smoking history, if any:
_____
_____

3. Diet and Weight:

What is a good weight for you? _____

What is the most you have ever weighed? _____

When ? _____ Weight one year ago? _____ Weight at age 21? _____

Is your present weight relatively stable? _____

Are you presently on a diet? _____

Is this diet supervised by a physician? _____

If dieting, describe: _____

Do you eat fresh or frozen fruits _____ and vegetables _____ daily? _____

If not, why not? _____

Do you eat three meals per day? _____

How many eggs do you eat per week? _____

How many times per week do you eat the following?

beef _____ pork _____ fish _____ fowl _____ fried foods _____ desert _____

How many glasses of milk do you drink daily? _____

Is it homogenized? _____ skimmed? _____ low fat? _____ buttermilk? _____

How much coffee (decaffeinated excluded) do you drink daily? _____

How much tea do you drink daily? _____ How much cola? _____

4. Physical Activity:

If employed, rate the physical activity level of your occupation:

light _____ moderate _____ heavy _____ hours per day _____

Are you currently involved in a regular exercise program or recreational physical activity? _____
If so, describe: _____
How many times per week? _____ Minutes per day? _____
Rate your level of exercise and/or physical activity on a scale of 1 to 5. (5 indicating very strenuous) for each age range through your present age:
15-20 _____ 20-30 _____ 30-40 _____ 40-50+ _____
Did you participate in high school or college athletics? If so, which ones? _____
_____
_____

Do you have negative feelings toward, or have you had any bad experiences with physical activity or physical activity
programs?_____
If yes, please explain:
_____
_____
_____
Do you start exercise programs, but unable to stick with them? _____
Is competition a necessary ingredient for your exercise program? _____
Are you able to exercise alone? _____
Is a group situation necessary for you to maintain an exercise program? _____
Characterize your present "physical fitness" level (Check one):
Excellent _____ Good _____ Fair _____ Poor _____

In consideration of being accepted into this training program, I certify that I have read and accurately completed this health form. I also declare that I have no concerns about my health that would affect my participation in a program of graded exercise testing or physical exercise, I will furnish this questionnaire to my physician.

_____ _____
Signature Date

II. PHYSICAL EXAMINATION FORM (To be completed by the physician):

NAME: _____ Today's Date: _____
Last First Middle

Age: _____ Weight: _____ Height: _____

Temperature: _____ Pulse Rate (resting): _____

Blood Pressure (seated) left arm _____ right arm _____

Health History (pertinent comments):

_____

_____

		Normal	Abnormal	Comments
HEAD				
	Eyes – Pupils			
	Eyes – Ocular Motion			
	Ears			
	Nasal Cavity			
	Mouth – Teeth			
	Mouth – Tongue			
	Mouth - Tonsils			
NECK				
	Thyroid			
	Cervical Nodes			
CHEST				
	Lungs			
	Heart - Sounds			
ABDOMEN				
GENITALIA				
MUSCULOSKELETAL				
	Cervical Spine			
	Thoracic Spine			
	Lumbar Spine			
	Shoulders			
	Elbows			
	Hips			
	Knees			
	Ankles			
	Hands			
	Feet			
	Other Joints			
NEUROLOGICAL				
	Reflexes			
	Other			
SKIN				
	Scars			

I have examined the above applicant and have found him/her to be medically qualified to participate in a program of physical exercise, including the graded exercise testing evaluation of the Police Officer Training Program. Physical exercises include graduated sit ups, leg raises/spreads, push-ups, ¼ to 10 mile runs, and wind sprints. I have also discussed with the applicant any health concerns documented on the consent form. Any exercise limitations are listed below:

Limitations:_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ Phone ( ) _____
Examining Physician (Printed Name) Area Number

Physician's Address: _____
Number Street City Zip code

_____ _____
Physicians Signature Date of Examination