DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CRIMINAL JUSTICE
POLICE TRAINING COMMISSION

HEALTH HISTORY STATEMENT (PTC-7)

Candidate's Name:_____

Social Security No._____ Date of Birth:_____

Candidate's Address:_____

Candidate's Employing Agency:_____

Police Training Commission-Approved School Candidate Will Attend:

Bergen County Law and Public Safety Institute

Name of Course: **Basic Course for Police Officers** Course Dates **7/20/18 – 12/14/18**

To the Candidate: Please complete **in ink** the following questionnaire concerning your past and present health. **Provide details for any positive answers on page 4 of this statement.** (You need not explain positive answers for question 16.) If additional pages are necessary, reproduce the last page. **FILL OUT THIS FORM IN FULL**

The information on this form will be used strictly to determine training eligibility and the information will be treated confidentially.

1. Name and address of family doctor_____
2. Date last seen and reason_____
3. Do you use tobacco products?_____What type?_____ How often?_____ Quantity?_____
4. Do you use alcoholic beverages? _____ If yes, what is your approximate intake of these beverages?

	None	Occasional	Often	Drinks per week?
Beer	_____	_____	_____	_____
Wine	_____	_____	_____	_____
Hard liquor	_____	_____	_____	_____

5. a. Have you taken any drugs or medications prescribed by a physician in the last year? Yes____ No_____

   b. Have you taken any over-the-counter or non-prescription medications in the last year? Yes____ No_____

   c. Are you now on medication? Yes____ No_____

6. a. Have you ever undergone a drug test for any employment of admission into a law enforcement training program? Yes____ No_____

   b. Have you ever produced a positive result on any drug test reported in 6a? Yes____ No_____

7. Do you have any hearing problem, or deafness?_____

8. Do you wear glasses, contact lenses or have any other eye disorder?_____

9. Do you have any dental problems?_____

10. Have you ever been hospitalized? _____ If, so, when?_____

11. Have you ever had surgery or operations?_____

12. Do you have any physical or mental condition that would prevent you from participating in any form of strenuous, prolonged exercise?_____

13. Do you participate in any regular exercise program or sport?_____
    If so, what kind and when did you begin?_____

14. Has your weight changed in the last year? Yes___ No___ How much?___ (+ or – lbs.)

15. Have you ever experienced any heat stress related emergencies, including heat fatigue, heat cramps, heat exhaustion or heat stroke?

16. Are you pregnant? Have you ever been pregnant? Have you given birth during the six week period of time preceding the start of the basic course?

17. Have you ever been discharged from the armed services for medicinal reasons? Yes___No___

<u>Family History</u>

	Age	Health or Cause of Death		Age	Health or Cause of Death
Mother			Father		
Brothers			Sisters		

Heart and Blood Vessels

18. Have you ever had high blood pressure?_____ When?_____
19. Have you ever had any type of heart trouble? (murmur, leaky valve, rheumatic fever, heart attack, coronary)?_____
20. Do you have any chest pain, skipped heart beats or palpitations?_____
21. Do you have any kind of circulation problem (cold hands or feet, leg pain while walking, varicose veins, swollen legs or ankles, vein problems, phlebitis)?_____
22. Have you ever had any type of stroke?_____

Lung Problems

23. Have you ever had any lung problem (shortness of breath, chronic cough, wheezing, asthma, emphysema, bronchitis, pneumonia)?_____
24. Are you now or have you ever used inhalers?_____When/how often?_____

Muscle-Bone_Joint Problems

Have you ever had:

25. Any type of back problem (slipped disc, low back strain, back pain, neck pain)?_____
26. Recurrent dislocations of any joint, recurrent strains or sprains or any type of arthritis?_____
27. Any athletic or other injury, broken bones, requiring medical attention?_____

Nervous or Mental Disorders

28. Have you ever had any nervous or emotional disorders (seizures, fits, epilepsy, blackouts, fainting spells, mental illness, depression, head injury or concussion)?_____

Allergies

29. Do you have any allergy problems (rash, hay fever, sinus trouble, wheezing, reaction to medicines? _____

Blood Sugar, Blood Tests, Cancer

30. Have you ever been told you had high or low blood sugar, abnormal cholesterol, anemia or other abnormal blood test, leukemia, or cancer?_____

Please list anything else which you feel may be important in your medical history, including any conditions not specifically referred to in the preceding questions.

Details of "yes" answers.

Place appropriate question numbers for responses.

Question Number Details

I understand that this Health History Statement will provide information for the physician to use in assessing my overall health for participation in a commission-approved basic course.

I hereby authorize a copy of this form to be released to the commission-approved school where I am enrolled.

I hereby certify that all statements are accurate and complete. Falsification of information on the Health History Statement may result in dismissal from the commission-approved school.

Signature in full_____ Date:_____

Print name in full:_____