

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 POLICE ACADEMY**

Name of Course: **Basic Course for Police Officers** Course Dates **07/17/2020 – 12/10/2020**

*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 or 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\_\_\_

Family History

	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?\_\_\_\_\_



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: \_\_\_\_\_