Form G-2	Kentucky Law Enforcement Council *MEDICAL HISTORY STATEMENT*	

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INSTRUCTIONS: To be completed by the applicant for a certifiable position prior to the physical examination and presented to the examining physician at the time of examination. All questions must be answered completely and accurately. **The original or a copy of this report must be retained in the personnel file by the employing agency.**

FORM G-2

MEDICAL HISTORY STATEMENT

This information is for official use only and will not be released to unauthorized persons.

Date: _____

Name: _____ Date of Birth: _____
Last First Middle

Address: _____

Telephone #: ( ) _____ SSN: _____/_____/_____

CURRENT MEDICATIONS
Prescription Medications: (Include pain relievers, birth control pills, etc.)

_____
Over the Counter Medications: (Include all cold allergy, headache, vitamins, etc.)

_____

ALLERGIES
Drug Allergies: (Include your reaction to the medication)

_____

_____
All Other Allergies: food, insects, seasons, animals, materials, etc.: (include reaction)

_____

_____

PAST MEDICAL HISTORY

List **ALL** hospitalizations and operations since childhood: Include type of surgery, date of surgery, and complications or other significant information

_____

_____

_____

Have you EVER, in your life, had any of the following types of medical problems: (check all that apply)

1. ☐ **CANCER:** any type of cancer including skin cancer, breast cancer, and leukemia
2. ☐ **MAJOR INFECTIOUS DISEASE:** such as tuberculosis, hepatitis, HIV/AIDS, rheumatic fever and others.
3. ☐ **NEUROLOGICAL PROBLEMS:** such as seizure disorder, stroke, concussion, severe headache, skull fracture, recurrent vertigo, balance problems, encephalitis, meningitis, tremors, multiple sclerosis, Huntington's chorea, peripheral neuropathy and others
4. ☐ **PSYCHOLOGICAL PROBLEMS:** such as depression, manic episodes, psychotic episodes, post-traumatic stress disorder and others
5. ☐ **EYE PROBLEMS:** such as eye injury, color blindness, poor night vision (night blindness), glaucoma, blindness in one or both eyes, very poor vision when not corrected and others
6. ☐ **EAR PROBLEMS:** such as ear injury, chronic ringing (tinnitus), chronic or long lasting ear infection, Meniere's disease, moderate to severe hearing loss in one or both ears and others
7. ☐ **NOSE PROBLEMS:** such as nose injury, allergies, nasal bleeding, and loss of sense of smell, chronic or long lasting infections and others
8. ☐ **MOUTH OR THROAT PROBLEMS:** such as injury, major dental work, any kind of speech defect, chronic or long lasting infections, abnormality of nose, mouth or throat that would interfere with wearing a respirator and others
9. ☐ **LUNG PROBLEMS:** such as asthma, emphysema, chronic or recurrent bronchitis, pneumonia, tuberculosis or lung abscess and others
10. ☐ **HEART AND CIRCULATION PROBLEMS:** such as a heart murmur, heart disease, heart attack, irregular rhythm, valve abnormalities, varicose veins, phlebitis, peripheral vascular disease, Raynaud's disease and others
11. ☐ **DIGESTIVE SYSTEM PROBLEMS:** such as any kind of ulcer disease, hepatitis or liver disorder, any kind of colitis, Crohn's disease, ulcerative colitis, irritable bowel syndrome, esophageal disorders, pancreatitis, gall stones, stomach or intestinal bleeding and others
12. ☐ **HORMONE OR ENDOCRINE PROBLEMS:** such as diabetes, thyroid disease, parathyroid or adrenal problems and others
13. ☐ **URINARY TRACK PROBLEMS:** such as kidney stones, pyelonephritis (kidney infection), nephrosis, single functioning kidney, polycystic kidney disease, repeated bladder infections and others

14. ☐ **HERNIA:** such as inguinal, umbilical, ventral, femoral, hiatal or incisional hernias
15. ☐ **MUSCLE, BONE AND JOINT PROBLEMS:** such as chronic back or neck pain, fibromyalgia, back or neck disease, osteomyelitis (bone infection), muscular dystrophy, arthritis, spinal curvature, loss of a finger or toe, and others
16. ☐ **BLOOD SYSTEM PROBLEMS:** such as anemia, hemophilia or bleeding disorder, white blood cell abnormality and others

MALES ONLY:

17. ☐ Prostate problems such as enlargement or prostatitis
18. ☐ Genital problems such as epididymitis or testicular injury

FEMALES ONLY:

19. ☐ Currently pregnant
20. ☐ History of endometriosis, pelvic inflammatory disease, abnormal Pap smear, PMS or other problem with your menstrual cycle

IMMUNIZATIONS

21. ☐ Have you ever had a positive TB test?
22. ☐ Have you received Hepatitis B vaccinations?
23. ☐ When did you receive your last tetanus (lockjaw) immunization? _____ ------

OCCUPATIONAL HISTORY

Have you ever been exposed to any of the following, whether at home, work, military or any other setting: {check all that apply}

24. ☐ Repetitive Loud Noises (including guns, jet engines, loud machinery)
25. ☐ Chemical exposure to skin or lungs
26. ☐ Dusty conditions (sandblasting, grinding, mining, drilling of rock, coal, slice, asbestos)

Check all YES answers:

27. ☐ Have you ever sustained an injury while at work that necessitated extended care by a health care provider?
28. ☐ Have you ever had a motor vehicle accident causing back or neck pain?
29. ☐ Are you limited or unable to perform any physical activity because of muscle or joint discomfort?
30. ☐ Do you have any missing limbs or non-functioning joints?
31. ☐ Have you ever been advised by a physician to avoid lifting above a certain weight limit?
32. ☐ Have you ever been advised by a physician to avoid sitting or standing over a certain time?
33. ☐ Have you ever worked in law enforcement?
    - ☐ 33a. If yes, have you ever missed more than three consecutive days of work for any medical or psychological problem?
34. ☐ Have you ever served in any of the armed forces?
    - ☐ 34a. If yes, have you ever missed other than three consecutive days of service for any medical or psychological problem?
35. ☐ Do you have any difficulty in properly holding, aiming or firing a handgun, rifle or shotgun?
36. ☐ Do you have difficulty driving at high speeds in a motorized vehicle?
37. ☐ Have you ever had an automobile accident while driving over sixty (60) miles per hour?
38. ☐ Have you ever had any automobile accidents as a result of losing control of your vehicle?
39. ☐ Do you have any difficulty driving for three (3) consecutive hours without stopping?
40. ☐ Do you have any difficulty running for five (5) consecutive minutes without stopping?

41. ☐ Have you ever passed out, temporarily lost control of any part of your body, or had blackout spells (episodes you do not remember)?

EXPLANATION OF ANY YES ANSWERS: (identify by number)
May use additional sheets of paper; write name, SSN, sign and date.

PENALTY:
Any falsification, withholding or failure to answer all questions completely and accurately may disqualify you from receiving employment or certification as a peace officer.

CERTIFICATION:
I hereby certify that there are no willful misrepresentations, omissions or falsifications in the foregoing statements and answers are true and correct to the best of my knowledge and belief.

Signature of Applicant

Date Signed

PHYSICIAN REVIEW:

Signature of Physician, Nurse Practitioner or Physician's Assistant (ink)

Date Reviewed

Printed Name and Address of Physician, Nurse Practitioner or Physician's Assistant Completing Review