Fire Academy
MEDICAL HISTORY STATEMENT

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS.

PAYMENT FOR SERVICES RENDERED IS THE RESPONSIBILITY OF THE INDIVIDUAL
SOUTHWESTERN COMMUNITY COLLEGE IS NOT RESPONSIBLE
FOR PAYMENT

INSTRUCTIONS:
To be completed by applicant for a certifiable position prior to the physical examination and presented to the examining qualified medical professional (Physician, Physician's Assistant, or Nurse Practitioner licensed to practice medicine in North Carolina), or Physician and/or Surgeon authorized to practice medicine in accordance with the rules and regulations of the U.S. Armed Forces, at the time of examination [12 NCAC 9B .0104(a)]. All questions must be answered completely and accurately. The original or a copy must be retained in personnel files by the appointing agency.

DATE: _____

NAME _____ DATE OF BIRTH ____/____/_____
Last First Middle

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE # (_____) _____-_____ Social Security # XXX-XX- _____

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

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

ALLERGIES
Drug Allergies: (Include your reaction to the mediation)
_____
_____
_____

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

(Continued next page)

PAST MEDICAL HISTORY

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

Have you **EVER**, in your life, had any of the following types of medical problems? [check all that apply to you]

_____ 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, 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 heart murmur, heart disease, heart attack, hypertension (high blood pressure) 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 TRACT 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, numbness fibromyalgia, back or neck disk disease, osteomyelitis (bone infection), muscular dystrophy, arthritis, spinal curvature, carpal tunnel syndrome 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? (Continued on next page)

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 or drilling of rock, coal, silica, 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 or other injury event 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-functional joints?
31. Do you have numbness, weakness, or pain in your upper extremities (including your hands)?
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 more than three consecutive days or service for any medical or psychological problem?

35. Do you have any medical condition that would prevent you from working extended shift periods, rotating shifts, or night shifts?
36. Do you have difficulty sitting for any extended period of time?
37. Have you ever been advised by a physician to avoid lifting above a certain weight limit?
38. Do you have any difficulty in properly holding, aiming or firing a handgun, rifle or shotgun?
39. Do you have any difficulty driving at high speeds in a motorized vehicle?
40. Have you ever had an automobile accident while driving over sixty (60) miles per hour?
41. Have you ever had any automobile accidents as a result of losing control of your vehicle?
42. Do you have any difficulty driving for three (3) consecutive hours without stopping?
43. Do you have any difficulty running for five (5) consecutive minutes without stopping?
44. Have you ever passed out, temporarily lost control of any part of your body, or had blackout spells (episodes you do not remember)?

(Continued on next page)

EXPLANATION OF ANY YES ANSWERS: (Identify by number)
Additional pages may be attached and must include your name, the last four digits of your social security number, and must be signed and dated.

PENALTY:
Any falsification, withholding or failure to answer all questions completely and accurately may disqualify you from receiving or retaining employment or certification as a criminal justice officer. Falsification regarding pre-existing conditions may disqualify you from receiving benefits from your employer.

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

_____ Signature of Applicant (Use Ink) Date Signed

QUALIFIED MEDICAL PROFESSIONAL REVIEW:

_____
_____
_____
Signature of Qualified Medical Professional Date Reviewed
(Use Ink) Name, Title and Address of qualified medical professional completing review

-- PLEASE TYPE OR PRINT CLEARLY--