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

HEALTH HISTORY STATEMENT

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: 7/19/19 - 12/12/19

To the Candidate: Please complete in ink the following questionaire concerning your past and present health. If you have an electronic copy of this form, it is a fillable .pdf, which can be typed and printed but cannot be saved.

Provide details for any positive answers on this statement.
(You need not explain positive answers for question 16.)
If additional pages are necessary, reproduce the last page.
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? ☐ Yes ☐ No What type?_____

How often? _____ Quantity? _____

4. Do you use alcoholic beverages? ☐ Yes ☐ No 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 any 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 6.a.? ☐ Yes ☐ No

7. Do you have any hearing problem or deafness? ☐ Yes ☐ No Explain:_____

_____

8. Do you wear glasses, contact lenses or have any other eye disorder? ☐ Yes ☐ No

Explain:_____

9. Do you have any dental problems? ☐ Yes ☐ No Explain:_____

_____

10. Have you ever been hospitalized? ☐ Yes ☐ No If so, when?_____

11. Have you ever had any surgery or operations? ☐ Yes ☐ No Explain:_____

_____

12. Do you have any physical or mental condition that would prevent you from participating in any form of strenuous, prolonged exercise? ☐ Yes ☐ No Explain:_____

_____

13. Do you participate in any regular exercise program or sport? ☐ Yes ☐ No

Explain:_____

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? ☐ Yes ☐ No Explain:_____

_____

16. Are you pregnant? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No

Have you given birth during the six-week period of time preceding the start of the basic course? ☐ Yes ☐ No

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

☐ Yes ☐ No

Family History

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

Heart and Blood Vessels

18. Have you ever had high blood pressure? ☐ Yes ☐ No When?_____

19. Have you ever had any type of heart trouble (murmer, leaky valve, rheutatic fever, heart attack, coronary?) ☐ Yes ☐ No Explain_____

_____

20. Do you have any chest pain, skipped heart beats or palpitations? ☐ Yes ☐ No

Explain_____

21. Do you have any kind of circulation problem (cold hands or feet, leg pain while walking, varicose veins, swollen legs or ankles, vein problem, phlebitis)? ☐ Yes ☐ No

Explain_____

22. Have you ever had any type of stroke? ☐ Yes ☐ No Explain_____

_____

Lung Problems:

23. Have you ever had any lung problem (shortness of breath, chronic cough, wheezing, asthma, emphysema, bronchitis, pneumonia)? ☐ Yes ☐ No Explain_____

_____

24. Are you now or have you ever used inhalers? ☐ Yes ☐ No When/how often?

_____

Muscle - Bone - Joint Problems

Have you ever had:

25. Any type of back problem (slipped disk, low back strain, back pain, neck pain)?

Explain_____

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, Mental or Emotional Disorders

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

☐ Yes ☐ No Explain_____

_____

Allergies

29. List and explain any allergy problems (food, rash, hay fever, sinus trouble, wheezing, reaction to medicines)_____

_____

Blood Sugar, Blood Tests, Cancer

30 List and explain any high or low blood sugar, abnormal cholesterol, thyroid, 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. Include details as to when the condition was treated, and whether treatment was successful. Place appropriate question numbers for responses. Attach additional pages as necessary.

Question #	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: _____