



# Medical Examination Form for Police Applicants

Police Department: \_\_\_\_\_

Examined by: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Applicant:

Surname: \_\_\_\_\_ Christian Names: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
(Street)

(City or Town) (Province) (Postal Code)

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

## Health History

Have you ever had or are you suffering from

	Yes	No		Yes	No		Yes	No
1. Illness or injuries since previous exam	<input type="checkbox"/>	<input type="checkbox"/>	12. Lung disease or chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	23. Back injuries and/or back problems	<input type="checkbox"/>	<input type="checkbox"/>
2. Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	13. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	24. Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
3. Ear trouble or deafness	<input type="checkbox"/>	<input type="checkbox"/>	14. Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	25. Foot troubles	<input type="checkbox"/>	<input type="checkbox"/>
4. Nose or throat trouble	<input type="checkbox"/>	<input type="checkbox"/>	15. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	26. Rheumatism or joint trouble	<input type="checkbox"/>	<input type="checkbox"/>
5. Hay fever – Asthma – Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	16. Rupture	<input type="checkbox"/>	<input type="checkbox"/>	27. Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>
6. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	17. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	28. Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>
7. Head injuries	<input type="checkbox"/>	<input type="checkbox"/>	18. Kidney and/or bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	29. Used alcoholic beverages to excess	<input type="checkbox"/>	<input type="checkbox"/>
8. Fainting spells – Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	19. Veneral disease	<input type="checkbox"/>	<input type="checkbox"/>	30. Operations	<input type="checkbox"/>	<input type="checkbox"/>
9. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	20. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	31. Allergies	<input type="checkbox"/>	<input type="checkbox"/>
10. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	21. Tropical diseases	<input type="checkbox"/>	<input type="checkbox"/>	32. Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>
11. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	22. Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	33. On any medication	<input type="checkbox"/>	<input type="checkbox"/>
34. Other: _____								

## Details of Positive Health History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Physique \_\_\_\_\_

Complexion \_\_\_\_\_ Skin disease(degree) \_\_\_\_\_ Hair colour \_\_\_\_\_ Eye colour \_\_\_\_\_

Chest measurements (male only)  
(a) Full inspiration \_\_\_\_\_ In. (b) Forced expiration \_\_\_\_\_ In.

Vision without aids		Vision with aids	
R	L	R	L
Glasses Required? Yes _____	If "Yes" are present ones satisfactory? _____	Yes _____	Colour vision (City University or Farnsworth D15 test) _____
No _____		No _____	

## Physical Examination

Blood Pressure		Pulse	
Systolic	Diastolic	Irregular <input type="checkbox"/>	Regular <input type="checkbox"/>
	Normal	Abnormal	
1. Lymphatic System	<input type="checkbox"/>	<input type="checkbox"/>	
2. Hearing (cv)			
R      L	<input type="checkbox"/>	<input type="checkbox"/>	
3. Ear (drums)			
R      L	<input type="checkbox"/>	<input type="checkbox"/>	
4. Head	<input type="checkbox"/>	<input type="checkbox"/>	
5. Nose (passages)	<input type="checkbox"/>	<input type="checkbox"/>	
6. Mouth (teeth)	<input type="checkbox"/>	<input type="checkbox"/>	
7. Throat (tonsils)	<input type="checkbox"/>	<input type="checkbox"/>	
8. Chest	<input type="checkbox"/>	<input type="checkbox"/>	
9. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
10. Heart	<input type="checkbox"/>	<input type="checkbox"/>	
11. Spine	<input type="checkbox"/>	<input type="checkbox"/>	
12. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
13. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
14. Genito-urinary	<input type="checkbox"/>	<input type="checkbox"/>	
15. Varicocele	<input type="checkbox"/>	<input type="checkbox"/>	
16. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	
17. Extremities			
(a) Hands	<input type="checkbox"/>	<input type="checkbox"/>	
(b) Feet	<input type="checkbox"/>	<input type="checkbox"/>	
(c) Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	
18. Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	

## Females Only

Breast Examination — to determine presence of nodules or tumors.

Gynaecological History — with pelvic examination including pap smear.

## Laboratory Examination

Blood Wassermann	Haemoglobin	E.S.R.	Blood group	Rh.
Urinalysis				
Albumen	Sugar		Microscopic	
Chest X-Ray (if necessary in physician's opinion)				
Film No.	Where taken			
Report:				
ECG — after age 39 years				
Other studies as deemed necessary				
Is applicant physically fit for employment as a Police Officer?      Yes <input type="checkbox"/> No <input type="checkbox"/> Temporary Rejection <input type="checkbox"/>				