NEW JERSEY STATE POLICE

Annual Medical History Form

Trooper to Complete:

DATE	BADGE #	NAME: *First*	*Last*	MI

GENDER	AGE	DATE OF BIRTH	CURRENT WEIGHT	CURRENT HEIGHT	BMI
◯ Female ◯ Male	_____ *Years*		_____ *lbs.*	_____ *feet* _____ *inches*	

UNIT CODE	ASSIGNMENT	SUPERVISOR

HOME PHONE	WORK PHONE	EXTENSION	CELL PHONE

Military Overseas Deployment? ◯ **Yes** ◯ **No**

If YES, describe any related symptoms you are experiencing:

Medications/Supplements? ◯ **Yes** ◯ **No**

(List all, including doses and frequency)

Allergies? ◯ **Yes** ◯ **No**

(List all, including food or medications)

Medical History
Trooper to Complete:

NAME: *First*	*Last*	MI	BADGE #

Personal Medical History for the Previous 365 Days

HEAD/NECK

- ☐ Head Trauma
- ☐ Concussion
- ☐ Dizzy Spells/Seizures
- ☐ Fainting
- ☐ Headaches/Migraine
- ☐ Neck Injuries
- ☐ Other _____

EYES

- ☐ Change in Vision

Describe:

- ☐ Eye Pain
- ☐ Eye Surgery/Lasik
- ☐ Flashes of Light
- ☐ Glasses/Contacts
- ☐ Partial Loss of Vision
- ☐ Other _____

Last Eye Exam: _____

EARS

- ☐ Frequent Earache
- ☐ Frequent Itching in Ears
- ☐ Hearing Aid
- ☐ Hearing Loss/Decreased Hearing
- ☐ Ringing in Ears
- ☐ Ruptured Eardrum
- ☐ Other _____

NOSE/THROAT

- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Enlarged Glands
- ☐ Fractured Nose
- ☐ Frequent Sinusitis
- ☐ Frequent Sore Throat
- ☐ Loss of Smell
- ☐ Nosebleeds
- ☐ Persistent Hoarseness
- ☐ Other _____

HEART/CIRCULATION

- ☐ Angina
- ☐ Ankle/Leg Swelling
- ☐ Irregular Heartbeat
- ☐ Chest Pain on Exertion
- ☐ Chest Pain, Pressure or Tightness
- ☐ Heart Attack
- ☐ Heart Disease/Disorder
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disorder
- ☐ High Blood Pressure
- ☐ Leg Cramp when Walking
- ☐ Persistent Fatigue
- ☐ Radiating Chest Pain to Arms, Jaw, Neck, Back
- ☐ Shortness of Breath
- ☐ Varicose Veins
- ☐ Other _____

GASTOINTESTINAL

- ☐ Abdominal Pain after Meals
- ☐ Bariatric Surgery
- ☐ Bloating/Gas/Cramping/Reflux
- ☐ Bloody or Painful BM
- ☐ Change in Bowel Habits
- ☐ Change in Size of Stool
- ☐ Weight Loss
- ☐ Food Intolerance
- ☐ Heartburn/Indigestion
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ History of Polyps
- ☐ Nausea/Vomiting
- ☐ Persistent Diarrhea
- ☐ Other _____

URINARY

- ☐ Blood in Urine
- ☐ Burning on Urination
- ☐ Difficulty Starting/Stopping
- ☐ Kidney/Bladder Stones
- ☐ Nighttime Frequency
- ☐ Sexually Transmitted Disease
- ☐ Other _____

LUNGS

- ☐ Abnormal Chest X-Ray
- ☐ Asbestos Exposure
- ☐ Asthma/Wheezing
- ☐ Chest Pain with Deep Breath
- ☐ Chronic Bronchitis
- ☐ Chronic Cough

Describe:

- ☐ Coughing Blood
- ☐ Emphysema
- ☐ Night Sweats
- ☐ Pneumonia/Pleurisy
- ☐ Pneumothorax/Collapsed Lungs
- ☐ Productive Cough
- ☐ Shortness of Breath

Describe:

- ☐ Shortness of Breath that interferes with job
- ☐ Occupational Exposure
- ☐ Snoring
- ☐ Gasping or Choking while Sleeping
- ☐ Stop Breathing while Sleeping
- ☐ Daytime Drowsiness or Sleepiness
- ☐ Sleepiness while Driving
- ☐ Tuberculosis
- ☐ Prescribed Inhalers
- ☐ Other _____

MENSTRUAL HISTORY

- ☐ Abnormal Pap
- ☐ Anemia
- ☐ Breast Lumps
- ☐ Heavy Bleeding
- ☐ Hot Flashes/Sweats
- ☐ Irregular Cycle
- ☐ Pregnancy Complication
- ☐ Severe Cramping
- ☐ Spotting
- ☐ Other _____

THYROID

- ☐ Brittle Nails/Hair
- ☐ Decrease/Increase in Appetite
- ☐ Goiter
- ☐ Hand Tremor
- ☐ Heat/Cold Intolerance
- ☐ Rapid/Slow Heartbeat
- ☐ Thyroid Nodule
- ☐ Weight Gain/Loss
- ☐ Other _____

SPINE/EXTREMITIES

- ☐ Amputation
- ☐ Backache/Injury
- ☐ Difficulty Bending at the Knees
- ☐ Difficulty Climbing a flight of stairs or ladder carrying more than 25 lbs.
- ☐ Difficulty Fully Moving your Head Up/Down or Side to Side
- ☐ Difficulty Squatting to Ground
- ☐ Dislocation
- ☐ Fractures
- ☐ Joint Pain
- ☐ Joint Swelling/Redness/Heat
- ☐ Sprains/Strains
- ☐ Weakness of Hands/Feet
- ☐ Numbness/Tingling of Extremities
- ☐ Other _____

Have you had injuries to the following:

- ☐ Ankle
- ☐ Elbow
- ☐ Foot
- ☐ Hand
- ☐ Knee
- ☐ Ligament
- ☐ Neck
- ☐ Shoulder
- ☐ Tendon
- ☐ Other _____

SURGERIES *(Type and Date))*

Medical History
Trooper to Complete:

NAME: *First*	*Last*	MI	BADGE #

Do you currently have or have you ever had:

CORONARY ARTERY DISEASE

- ☐ Aspirin _____
- ☐ Other Anti-Platelet Meds (Plavix/Ticlid/Coumadin) _____
- ☐ Beta Blockers (Teprol, Coreg, etc.) _____
- ☐ ACE Inhibitor _____
- ☐ Stent _____
- ☐ CABG _____
- ☐ Angioplasty _____

DIABETES

- ☐ HgbA1c Last _____
- ☐ Statins Use _____
- ☐ FBS Last _____
- ☐ Aspirin _____

MEDICAL TESTS *(Provide Dates if Applicable)*

- ☐ CAT Scan _____
- ☐ Cardiac Catheterization _____
- ☐ Chemotherapy _____
- ☐ Chest X-Ray _____
- ☐ Coronary CTA _____
- ☐ EKG _____
- ☐ MRI _____
- ☐ Mammogram _____
- ☐ PAP _____
- ☐ PSA _____
- ☐ Radiation Therapy _____
- ☐ Stress Test _____
- ☐ Ultrasound _____
- ☐ Other _____

Have you been told to have any procedures that you have not had done? ◯ Yes ◯ No *If yes, list below:*

SUBSTANCES

- ☐ Smoke Cigarettes *Packs per Day:* _____
- ☐ Smoke Cigars *Number per Day:* _____
- ☐ Chew Tobacco *Amount per Day:* _____
- ☐ Drug Dependency
- ☐ Treatment for Alcoholism
- ☐ Other *(Describe):*

MOOD SCREENING *ALL BOLD QUESTIONS MUST BE ANSWERED*

During the past month

Have you often been bothered by feeling down, depressed or hopeless?
◯ Yes ◯ No

Have you often been bothered by little interest or pleasure in doing things?
◯ Yes ◯ No

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you:

Have had nightmares about it or thought about it when you did not want to?
◯ Yes ◯ No

Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
◯ Yes ◯ No

Were constantly on guard, watchful, or easily startled?
◯ Yes ◯ No

Felt numb or detached from others, activities, or your surroundings?
◯ Yes ◯ No

ALCOHOL SCREENING *ALL BOLD QUESTIONS MUST BE ANSWERED*

Do you sometimes drink beer, wine, or other alcoholic beverages?
◯ Yes ◯ No

How many times in the past year have you had:

(Men) 5 or more drinks in a day? _____

(Women) 4 or more drinks in a day? _____

On average, how many days a week do you have an alcoholic drink? _____

On a typical drinking day, how many drinks do you have? _____

In the past 12 months has your drinking repeatedly caused or contributed to:

- ☐ Risk of bodily harm (e.g., while operating machinery, swimming, etc.)
- ☐ Relationship trouble (family or friends)
- ☐ Role failure (e.g., interference with home, work, parental or marital relationships)
- ☐ Trouble with administrative, financial or legal issues

In the past 12 months have you:

- ☐ Not been able to limit your drinking when you tried to?
- ☐ Not been able to cut down or stop?
- ☐ Needed to drink a lot more to get the same effect?
- ☐ Experienced tremors, nausea, sweating or insomnia when trying to quit or cut down?
- ☐ Kept drinking despite problems - physical or psychological?
- ☐ Spent a lot of time planning your drinking or recovering from drinking?
- ☐ Spent less time on activities that are usually important or pleasurable to you?

Medical History
Physician to Complete:

NAME: *First*	*Last*	MI	BADGE #

EXAMINATION	FINDINGS/COMMENTS
BLOOD PRESSURE: _____ If Systolic >140, serial pressures to be taken Ht. _____ Wt. _____	
HEAD: Symmetry or deformity _____	
NECK: Nodes _____	
EYES: Pupils round, regular, react to light and accomodations _____ **Vision:** Corrected ☐ OD ☐ OS ☐ OU Uncorrected ☐ OD ☐ OS ☐ OU	
EARS: Otoscopic visualization of eardrums _____	
NOSE: _____	
THROAT: Thyroid _____	
CHEST: _____	
HEART: Rate: _____ Rhythm: _____ Murmur: _____	
CIRCULATION: Pulses _____	
SKIN: Melanoma _____	
MUSCULOSKELETAL: _____	
ABDOMEN: _____	
NEUROLOGICAL: _____	
RECTAL: _____	
GENITALIA: _____	

Medical History
Physician to Complete:

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REVIEW OF MEDICAL HISTORY, EXAMINATION , AND ALL TESTING

EKG Reviewed ○ Yes ○ No

Abnormal findings ○ Yes ○ No

Describe: _____

Labwork Reviewed ○ Yes ○ No

Abnormal findings *(list)*: _____

Audiogram Reviewed: ○ Yes ○ No

Summary of Findings:

Recommendations:

_____ _____ _____
Date *Signature of Trooper* *Badge No.*

_____ _____
Date *Signature of Examining Physician*