

Village Public Safety Officer

Medical History Questionnaire

Applicant Name: _	 	
Agency:		
Date completed: _		

This personal and medical history questionnaire must be completed and submitted to the State of Alaska VPSO Division office before employing an individual as a VPSO, AS 18.65.674.

Note to potential employer: Paper or electronic copies of this form should be maintained in a separate file to ensure confidentiality.



Department of Public Safety

VILLAGE PUBLIC SAFETY OFFICER DIVISION

5700 East Tudor Road Anchorage, Alaska 99507-1225 Main: 907-334-2243 Fax: 907-337-2059

MEDICAL HISTORY QUESTIONNAIRE

COMPLETE THIS FORM PRIOR TO YOUR PHYSICAL EXAMINATION AND GIVE IT TO THE EXAMINER AT THE TIME OF EXAMINATION. CANDIDATE'S NAME (Last, First, Middle) ADDRESS DATE OF BIRTH AGE CURRENT OCCUPATION HIRING AGENCY Have you ever or do you now have any of the following? For "**YES**" answers, list the question number and supply full details in **Section "B"** on page 2. If the condition required hospitalization, check the corresponding '**HOSP**' box. **SECTION** HOS HOS **CONDITION** YES CONDITION YES NO NO P P 1. Head injury 21. Skin condition Any defects of bones or joints including amputations, broken bones or dislocations 22. Any complications from childhood 3. Back trouble or back pain 23. Sensitivity to dust 4. Pernicious anemia, leukemia 24. Other allergies 5. Rheumatism or arthritis 25. Cancer or malignancy 6. Trick or locked knee/knee injury 26. Tumor, growth, or cyst 7. Foot trouble 27. Polio 8. Eye injury, surgery, or disease 28. Rheumatic fever 29. Heart trouble (including circulatory) 9. Have you ever worn glasses /contact 10. Hard of hearing or hearing problems 30. High or low blood pressure 11. Headaches 31. Varicose veins 12. Mental illness or nervous breakdown 32. Diabetes or sugar in urine 13. Addiction to drugs or alcohol Colitis 34. Gall bladder trouble 14. Fainting or dizzy spells, epilepsy 15. Hepatitis, jaundice, liver ailment 35. Kidney or bladder trouble 16. Disorder of the nervous system Hemorrhoids or piles 17. Tuberculosis or lung disease 37. Rupture or hernia 18. Shortness of breath or asthma 38. Mononucleosis 39. Any contagious disease 19. Any type of blood disorder

20. Bronchitis

Answer the following questions. For "YES" answers, list the question number and supply full details in Section B below.						
40. Ha	40. Have you ever had or been advised to have an operation?					
41. Ha	41. Have you ever been a patient (committed or voluntary) in a mental hospital?					
42. Ha	ive you ever	had any other illness, injury, or physical condition not named on this form?				
43. Are	e you preser	tly under a doctor's care for any condition?				
44. Ha	ive you taker	n any medication during the last 12 months?				
45. Do	you have a	ny physical or emotional limitations?				
46. Ha	ave you ever	been treated or received counseling for drug abuse?				
47. Do	you smoke	? If "YES", number of packs per day:				
48. Do	you drink?	If "YES", number of drinks per week:				
49. Ha	ive you had a	an injury within the last 5 years which caused you to lose time from work?				
50. Ha	ive you even	been denied employment or insurance for medical reasons?				
51. Ha	ve you even notional reas	been discharged or released from employment or the armed forces for medical or ons?				
52. Ha	52. Have you ever received or applied for a pension or compensation for disability or injury?					
SEC	Please explain all items answered "YES," in this questionnaire; identify question number, date of onset, diagnosis and your present condition.			ion		
# DATE DETAILS						

Name of Applicant (Printed):	

MEDICAL EXAMINER CONSULTATION (for any of the questions answered " yes ", identify the question number and complete examiner's name and address information.)				
DAT		ADDDECC	(Number, S	treet, City, State, Zip)
By signing be	elow, I	(printed na	me) certify to	the best of my knowledge and
				e to report completely and
				certification as a Village Public
Safety Office	r.			
Signed in (city	and state):			
Applicant Sign	nature:		Date:	
11				
Witnessed by	(Printed Name)	Sigr	ature:	
,, iniessed by	(1 Inter Paine).	51g1		
HEALTH QU	ESTIONNAIRE REVIE	WED BY (Printed Name		XAMINER'S NAME, ADDRESS, AND ELEPHONE #
<u>. </u>				
-				
EXAMINER'S	SIGNATURE	DATE_		