Municipal Fire and Police Retirement System of Iowa
Medical History Questionnaire – To Be Completed by the Applicant

NAME:_____ DATE:_____
JOB TITLE: _____ PHONE: _____
DOB: _____ SSN: _____ AGE: _____
TYPE OF EXAM: ☐ Post Offer ☐ Medical Surveillance ☐ Other

Mark "yes" or "no" to the following questions. For EVERY answer marked "YES," please provide an explanation in the space provided on the next page. **For injuries you must specify the location of the injury, i.e. right ankle or left ankle; right knee or left knee, etc.**

HAVE YOU EVER HAD:	Yes	No
Allergic reactions to medicines…		
Allergic reactions to chemicals, oils, or foods ……..		
Skin rashes or eczema……		
Asthma/wheezing……..		
Hay fever……		
Bronchitis……		
Shortness of breath while walking……		
Tightness of chest……..		
Persistent cough or phlegm……..		
Tuberculosis……		
Pneumonia……..		
Emphysema……		
Sleep apnea……		
Do you use tobacco products? *..		
Have you ever used tobacco products? *……..		

*On next page list type(s) used and frequency of use of each. Also, list start and quit dates for each product used.

HAVE YOU EVER HAD:	Yes	No
Any other respiratory problems…		
Any hospitalizations/surgeries….		
High blood pressure……..		
Chest pain or pressure……..		
Heart attack……		
Heart surgery……		
Swelling of ankles……..		
Fainting/dizzy spells……..		
Varicose veins……		
Palpitations/skipped beats……		
Heart murmur……		
Any other heart disease/condition or tests…….		

HAVE YOU EVER HAD:	Yes	No
Stomach ulcers……..		
Frequent nausea……..		
Frequent bowel trouble……...		
Frequent diarrhea……..		
Hernia……..		
Bloody or black stools……		
Any other stomach/bowel diseases or problems……..…		
Loss of consciousness……		
Fits, convulsions, or seizures…..		
Frequent hand/forearm pain……		
Numbness of hands and/or feet……..		
Decrease in grip strength…….		
Severe headaches……		
Migraine headaches……		
Claustrophobia, fear of enclosed spaces……		
Emotional/psychiatric disease….		
Depression……		
Weakness in arms or legs……		
Other neurological problems…...		
Back trouble or pain……..…...		
Back or neck injury……..		
Back pain when lifting ……..		
Shoulder surgery*……		
Back or neck surgery*……		
Knee surgery*……		

*On next page list any physical restrictions as a result of surgery

Swollen joints……		
Dislocated shoulder……..		
Rheumatism or arthritis……		
Fracture or broken bone……..…		

HAVE YOU EVER HAD:	Yes	No
Ankle sprain(s)……..		
Any other bone/joint problems…		

DO YOU WEAR GLASSES:	Yes	No
For reading……..		
For distance……		
Do you wear contact lenses……		
Are you color blind/impaired……		
Other vision problems……		
Any difficulties with vision at night……		

HAVE YOU EVER HAD:	Yes	No
Ear surgery……		
Ear trouble……..		
Difficulty hearing……		
Hearing aids……..		
Blood in urine……		
Kidney trouble……		
Urination difficulties……..		
Bladder trouble……..		
Liver trouble……..		
Hepatitis……..		
Jaundice……		
Gallbladder trouble……		
Diabetes or sugar in urine……..		
Do you require insulin……..		
Have you ever passed out or had an altered level of alertness due to your diabetes……..		
Needed the help of others for your diabetes……		
Thyroid trouble or goiter……...		

Continued on next page

Revised: 04.06.11

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Medical History Questionnaire

NAME: _____ SSN: _____

Mark "yes" or "no" to the following questions. For EVERY answer marked "yes," please provide an explanation in the space provided below. Indicate the location(s) of the injury(s) or condition(s); i.e. – right knee or left knee. If additional space is needed, please use the back of this page.

HAVE YOU EVER HAD:	Yes	No
Cancer……		
Heat exhaustion or heat stroke...		
Anemia……		
Leukemia or lymphoma …..		
A blood transfusion……		
Do you bleed easily?……		
Have you ever been treated by radiation or chemotherapy ……		
Have you ever worked with radioactive material?……		

	Yes	No
Are you taking medicine(s) regularly?……		
Are you taking any herbal or over-the-counter medications?...		
Are you or have you ever used any illegal drugs?*…… *Below, list drug(s) used and start/quit dates		
Do you drink any alcohol?*……. *Below, list type(s) used, how much of each, frequency of use, and where each is consumed.		

HAVE YOU EVER:	Yes	No
Worn a respirator*……. *Below, list what job you were performing and for which employer.		
Had any difficulties wearing a respirator……		

List the date of your last: (if you have not had these shots/vaccinations, indicate "none")

	Date		Date
Tetanus shot…..……		Flu shot, if ever……...	
Hepatitis B vaccine, if ever…..		Pneumonia vaccine, if ever…..	

From both pages, please explain all "YES" answers in the space provided below.

If additional space is needed, please use the back of this page.

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NAME: _____ SSN: _____

Applicant's Declaration and Notice Regarding Pre-existing Medical Conditions

I understand that this physical examination is for job placement purposes or is required by my employer and is not a complete physical exam. I understand that I should see my personal physician if I wish to receive a complete physical exam. The information I have provided is true and correct to the best of my knowledge. I understand that failure to truthfully complete this form may result in my termination, disciplinary action, and/or denial of disability benefits for a condition not identified.

I understand that Iowa Code section 411.6 provides that I will not be eligible for a disability pension from the fire and police retirement system for a medical condition that would not exist absent a medical condition that was known to exist on the date my membership commenced. I hereby acknowledge that any medical condition identified in any manner during this medical examination process is known by me to exist at the time my membership in the retirement system commences. I further certify that I have completed this form accurately and completely.

Signature: _____ Date: _____