

**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:		
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**



Municipal Fire and Police Retirement System of Iowa  
Medical History Questionnaire

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: \_\_\_\_\_