MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
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# Medical History Questionnaire

For completion by applicant

First Name _____ Last Name _____ Date _____

Job Title _____ Phone _____ Date of Birth _____ Last 5 Digits of SSN _____

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 of phlegm | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Pneumonia | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Sleep apnea | ☐ | ☐ |
| Have you ever used tobacco products?* | ☐ | ☐ |

*On the 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 | ☐ | ☐ |
| Dislocated shoulder | ☐ | ☐ |
| Rheumatism or arthritis | ☐ | ☐ |
| Fracture or broken bone | ☐ | ☐ |
| Swollen joints | ☐ | ☐ |
| Shoulder surgery** | ☐ | ☐ |
| Back or neck surgery** | ☐ | ☐ |
| Knee surgery** | ☐ | ☐ |

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

| Have you ever had: | Yes | No |
|---|---|---|
| Ankle sprain(s) | ☐ | ☐ |
| Any other bone/joint problems | ☐ | ☐ |

| Do you wear eyeglasses: | Yes | No |
|---|---|---|
| For reading | ☐ | ☐ |
| For distance | ☐ | ☐ |
| Do you wear contact lenses | ☐ | ☐ |
| Are you color blind/impaired | ☐ | ☐ |
| Other vision problems | ☐ | ☐ |
| 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 | ☐ | ☐ |
| 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 | ☐ | ☐ |
| Thyroid trouble or goiter | ☐ | ☐ |

**Continued on next page**

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First Name _____ Last Name _____ Last 5 Digits of SSN _____

Mark "yes" or "no" to the following questions. For **every** answer marked "**yes**," please provide an explanation in the space provided at the bottom of the 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 |
|---|---|---|
| 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 illegal drugs# | ☐ | ☐ |
| Do you drink any alcohol## | ☐ | ☐ |
| #Below, list drug(s) used and start and quit dates. | | |
| ##Below, list type(s) of alcohol used, how much of each, frequency of use, and where each is consumed. | | |

| Have you ever had: | Yes | No |
|---|---|---|
| Worn a respirator^ | ☐ | ☐ |
| Had any difficulties wearing a respirator^ | ☐ | ☐ |
| ^Below, list what job you were performing and for which employer. | | |

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

| | Date |
|---|---|
| Tetanus shot | |
| Hepatitis B vaccine, if ever | |

| | Date |
|---|---|
| Flu shot, if ever | |
| Pneumonia vaccine, if ever | |

From both page 1 and page 2, please explain all "yes" answers in the space provided below.

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**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 _____