MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA

7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Medical History Questionnaire - For completion by applicant

First Name ________ Last Name ________ Last 5 Digits of SSN ________

Employing City ________ ☐ Police ☐ Fire Phone ________ Date of Birth ________

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		
Any 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		

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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