Metro Public Health Department
Occupational Health and Wellness Center/CSM
311 23rd Avenue North
Nashville, TN 37203

Pursuant to the Federal Privacy Act (Public Law 93-579 and the Information Practices Act (IPA) of 1977 (Civil Code Sections 1798*, et seq.*), notice is hereby given for the request of personal information. Failures to provide all or any part of the requested information may delay processing of this form, or result in an incomplete record. No disclosure of personal information will be made unless legally permissible. Pages 1, 2, and 3 must be initialed at the bottom and page 4 must be signed and dated.

## INSTRUCTIONS

- Metro procedures require that certain applicants and employees be examined by a licensed Metro Public Health physician to ensure the absence of any physical defect or medical condition which might adversely affect job performance.
- The information you provide in this statement is extremely important. It will be used by a medical health professional to evaluate your employment qualifications. Specific details of the functions of your job classification are available form the appointing authority. Therefore, please fill out the questionnaire completely and accurately. Please keep in mind that: (a) all statements are subject to verification; (b) deliberate inaccuracies or incomplete statements may bar or remove you from employment.
- This form must be completed and presented when reporting for your medical examination. This information will assist the examining physician in conducting your medical examination and in making appropriate recommendations.
- When answering questions, place an "X" in the appropriate box. ALL ITEMS MUST BE COMPLETED. Please explain all "Yes" items in the designated areas. Almost all individuals will have some "Yes" answers. A "Yes" answer does not necessarily have any effect on employability.
- This statement is confidential. The information you provide will be part of your medical record, separate from your personnel file.
- Type or legibly print (in ink) all required information on printed form.

## SECTION 1: APPLICANT/EMPLOYEE IDENTIFICATION

APPLICANT/EMPLOYEE'S NAME (Last, First, Middle)

**PLACE ID STICKER HERE**

*E-MAIL TO RECEIVE PERSONAL HEALTH INFORMATION. IF NONE MARK "X"*

email:

## SECTION 2: CONSENT

I, the undersigned, do hereby consent to undergo a medical examination, including blood and urine testing, x-rays, skin tests, and other examinations which the examiner may consider necessary to complete the medical evaluation. I also authorize the medical examiner to obtain current or past medical records and to discuss my medical status and history with my treating physician or other medical providers as necessary. I specifically DO NOT consent to the use of any specimen to test for drugs or alcohol, and I specifically REFUSE any request for such testing as part of this examination.

SIGNATURE | DATE

## SECTION 3: JOB/WORK HISTORY – NEW APPLICANTS ONLY, ***NOT CURRENT EMPLOYEES***

Please list previous 6 jobs that lasted at least six (6) months, including military service.

| JOB TITLE | EMPLOYER / LOCATION (CITY, STATE, OR COUNTRY IF OVERSEAS) | EMPLOYMENT DATES (MM/DD/YYYY) |
|---|---|---|
| | | – |
| | | – |
| | | – |
| | | – |
| | | – |
| | | – |



INITIALS_____

# NEW PATIENT MEDICAL HISTORY STATEMENT



**SECTION 4: MEDICAL HISTORY –** Indicate if you have ever had any of the following conditions. Place only 1 checkmark for each number

| | Y | N | ? | EYE, EAR, NOSE, THROAT |
|---|---|---|---|---|
| 1 | ☐ | ☐ | | Eye surgery |
| 2 | ☐ | ☐ | | Need to wear glasses / contact lenses |
| 3 | ☐ | ☐ | ☐ | Cataracts |
| 4 | ☐ | ☐ | | Blurred or double vision |
| 5 | ☐ | ☐ | ☐ | Color deficiency or blindness to any degree |
| 6 | ☐ | ☐ | ☐ | Glaucoma |
| 7 | ☐ | ☐ | | Radial keratology (refractive surgery) or keratotomy, or LASIK surgery |
| | RESERVED | | | |
| 9 | ☐ | ☐ | | Sinus trouble |
| 10 | ☐ | ☐ | | Hoarseness (frequent or recent) |
| 11 | ☐ | ☐ | | Allergy / hay fever |
| 12 | ☐ | ☐ | | Ruptured ear drum |
| 13 | ☐ | ☐ | | Ringing or buzzing in ears |
| 14 | ☐ | ☐ | | Loss of hearing |
| 15 | ☐ | ☐ | ☐ | Ear surgery/Tubes in ears |
| 16 | ☐ | ☐ | ☐ | Earaches |
| | Y | N | ? | RESPIRATORY |
| 17 | ☐ | ☐ | | Asthma (list age of last episode: _____) |
| 18 | ☐ | ☐ | | Shortness of breath |
| 19 | ☐ | ☐ | | Chronic or frequent cough |
| 20 | ☐ | ☐ | ☐ | Positive Tuberculosis Skin Test |
| 21 | ☐ | ☐ | ☐ | Emphysema |
| 22 | ☐ | ☐ | | Coughed up blood |
| 23 | ☐ | ☐ | | Pneumothorax (collapsed lung) |
| 24 | ☐ | ☐ | | Pneumonia |
| 25 | ☐ | ☐ | ☐ | Sarcoidosis |
| 26 | ☐ | ☐ | | Chest tightness |
| 27 | ☐ | ☐ | | Wheezing |
| 28 | ☐ | ☐ | | Blood clot in lungs |
| | Y | N | ? | GASTROINTESTINAL |
| 29 | ☐ | ☐ | | Ulcer |
| 30 | ☐ | ☐ | | Vomited blood |
| 31 | ☐ | ☐ | | Persistent diarrhea |
| 32 | ☐ | ☐ | ☐ | Colitis |
| 33 | ☐ | ☐ | | Recurrent hemorrhoids |
| 34 | ☐ | ☐ | | Gall bladder trouble |
| 35 | ☐ | ☐ | | Hepatitis/jaundice (skin or eyes turn yellow) |
| 36 | ☐ | ☐ | | Recurrent stomach pain |
| 37 | ☐ | ☐ | ☐ | Mucous in stool |

| | | | | |
|---|---|---|---|---|
| 38 | ☐ | ☐ | ☐ | Pancreatitis |
| 39 | ☐ | ☐ | | Abnormal liver tests |
| 40 | ☐ | ☐ | | Hernia |
| 41 | ☐ | ☐ | ☐ | Ulcerative colitis |
| | RESERVED | | | |
| 44 | ☐ | ☐ | ☐ | Crohn's disease |
| | Y | N | ? | GENITOURINARY |
| | RESERVED | | | |
| 46 | ☐ | ☐ | | Bladder trouble |
| 47 | ☐ | ☐ | | Difficulty in urinating |
| 48 | ☐ | ☐ | | Blood in urine |
| 49 | ☐ | ☐ | | Prostate trouble |
| 50 | ☐ | ☐ | | Irregular vaginal bleeding |
| | RESERVED | | | |
| 52 | ☐ | ☐ | ☐ | Currently pregnant |
| | Y | N | ? | CARDIOVASCULAR |
| 53 | ☐ | ☐ | | Heart attack or chest pain |
| 54 | ☐ | ☐ | | Heart murmur |
| 55 | ☐ | ☐ | ☐ | Mitral valve prolapse |
| 56 | ☐ | ☐ | | Palpitation (irregular heartbeat) |
| 57 | ☐ | ☐ | | High blood pressure |
| 58 | ☐ | ☐ | | Discomfort in chest |
| 59 | ☐ | ☐ | ☐ | Rheumatic fever |
| 60 | ☐ | ☐ | | Swelling of feet or ankles |
| 61 | ☐ | ☐ | | Leg cramps when walking |
| 62 | ☐ | ☐ | ☐ | Painful varicose veins |
| | Y | N | ? | MUSCULO SKELETAL |
| 63 | ☐ | ☐ | | Fractures / broken bones |
| 64 | ☐ | ☐ | | Back trouble / pain or sciatica |
| 65 | ☐ | ☐ | | Neck trouble / pain |
| 66 | ☐ | ☐ | | Numbness of extremities |
| 67 | ☐ | ☐ | | Shin pains |
| 68 | ☐ | ☐ | ☐ | Arthroscopy |
| 69 | ☐ | ☐ | | Arthritis / rheumatism |
| | Y | N | ? | JOINT INJURY / SURGERY / DISLOCATION / PAIN / SWELLING |
| 70 | ☐ | ☐ | ☐ | Shoulder |
| 71 | ☐ | ☐ | ☐ | Elbow |
| 72 | ☐ | ☐ | ☐ | Wrist |
| 73 | ☐ | ☐ | ☐ | Fingers / toes |

| | | | | |
|---|---|---|---|---|
| 74 | ☐ | ☐ | ☐ | Hip |
| 75 | ☐ | ☐ | ☐ | Knee |
| 76 | ☐ | ☐ | ☐ | Ankle/ foot |
| | Y | N | ? | NEURO-PSYCHIATRIC |
| 77 | ☐ | ☐ | ☐ | Epilepsy |
| 78 | ☐ | ☐ | | Convulsions / seizures |
| 79 | ☐ | ☐ | | Fainting spells / blackouts |
| 80 | ☐ | ☐ | | Recurrent dizziness |
| 81 | ☐ | ☐ | | Head injury |
| 82 | ☐ | ☐ | | Frequent / recurrent headaches |
| 83 | ☐ | ☐ | | Stroke |
| | RESERVED | | | |
| 85 | ☐ | ☐ | ☐ | Meningitis / encephalitis |
| | RESERVED | | | |
| 87 | ☐ | ☐ | | Mental hospitalization |
| 88 | ☐ | ☐ | | Attention deficit disorder |
| 89 | ☐ | ☐ | ☐ | Dyslexia |
| | Y | N | ? | MISCELLANEOUS |
| 90 | ☐ | ☐ | | Diabetes (glucose in urine) |
| 91 | ☐ | ☐ | | Low blood sugar |
| 92 | ☐ | ☐ | | Thyroid trouble |
| 93 | ☐ | ☐ | | Bleeding tendencies |
| 94 | ☐ | ☐ | | Anemia |
| 95 | ☐ | ☐ | ☐ | Enlarged lymph nodes |
| 96 | ☐ | ☐ | ☐ | Cyst / tumor |
| 97 | ☐ | ☐ | | Skin problems / rashes |
| 98 | ☐ | ☐ | | Wool allergy |
| 99 | ☐ | ☐ | | Non-healing sores |
| 100 | ☐ | ☐ | | Recent change in a wart or mole |
| 101 | ☐ | ☐ | | Cancer / leukemia |
| 102 | ☐ | ☐ | ☐ | Chronic fatigue |
| 103 | ☐ | ☐ | ☐ | Night sweats |
| 104 | ☐ | ☐ | | Undesired weight loss or gain >15 lbs |
| 105 | ☐ | ☐ | | Heat stress |
| 106 | ☐ | ☐ | ☐ | Environment illness |
| 107 | ☐ | ☐ | ☐ | Multiple chemical sensitivity |
| 108 | ☐ | ☐ | ☐ | Fever lasting 1 month or more |
| 109 | ☐ | ☐ | ☐ | Eczema |
| 110 | ☐ | ☐ | | Gulf War Syndrome |
| 111 | ☐ | ☐ | | Any other problem or illness not listed that may affect job performance |



INITIALS_____

## SECTION 5: MEDICAL CONDITION EXPLANATION(S)

Provide explanations for any medical condition(s) marked "yes" in Section 4. Reference the corresponding item number in your response.

| ITEM # | EXPLANATION | ITEM # | EXPLANATION |
|---|---|---|---|
| | | | |
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## SECTION 6: OTHER MEDICAL

Please answer each of the following questions:

| Y | N | ? | | |
|---|---|---|---|---|
| ☐ | ☐ | | 112. | Have you ever had a medical exam for employment as a public safety or law enforcement officer OTHER THAN WITH METRO?<br>If yes, a) What year? _____ b) For what agency / municipality: _____ |
| ☐ | ☐ | | 113. | Have you worked as a public safety or law enforcement officer elsewhere? If yes, where: _____ |
| | | | 114. | Describe your typical exercise or physical activity including that at work; indicate how often and how long you've been doing it. |

| | EXERCISE / ACTIVITY | HR/Wk | HOW LONG? |
|---|---|---|---|
| a) | | | years months |
| b) | | | years months |
| c) | | | years months |

| | | | |
|---|---|---|---|
| ☐ | ☐ | 115. | Have you ever coughed, wheezed, or had chest discomfort <u>after exercise</u>? |
| ☐ | ☐ | 116. | Do you ever become short of breath <u>when walking with other people of your own age at level ground</u>? |
| ☐ | ☐ | 117. | Do you currently smoke cigarettes? If yes, a) How many packs per day? b) For how long (in years)? |
| ☐ | ☐ | 118. | Are you an ex-smoker? If yes, a) How many years did you smoke? b) How many packs per day? c) What year did you quit? |
| ☐ | ☐ | 119. | Are you now or have you ever been enrolled in a drug or alcohol rehabilitation program? If yes, please give description and dates. |

| | PROGRAM | FROM – TO (MM/DD/YYYY) |
|---|---|---|
| a) | | – |
| b) | | – |

120. When was your last alcoholic drink? _____ a) ☐ I do not drink alcohol. b) ☐ I am a light drinker (two or less drinks per week).
c) I drink (per week): bottles/cans of beer glasses of wine bottles of wine shots of hard liquor

| | | | |
|---|---|---|---|
| ☐ | ☐ | 121. | Do You chew tobacco? If yes, how much per day: _____ |
| ☐ | ☐ | 122. | Have you recently (last 10 days) been exposed to smoke or any noxious or chemical fumes? |

123. Describe any past or current hobbies, side jobs or recreational activities that expose(d) you to noise or chemicals.

| | HOBBY / ACTIVITY/JOB | TYPE OF NOISE / CHEMICAL |
|---|---|---|
| a) | | |
| b) | | |

| | | | |
|---|---|---|---|
| ☐ | ☐ | 124. | Have you been exposed to loud noise in the last 14 hours? If yes, were you wearing ear protection? ☐ Yes ☐ No |
| ☐ | ☐ | 125. | Have you ever been unable to hold a job or been refused employment because of any physical, mental, or other medically related reason? |
| ☐ | ☐ | 126. | Have you ever been rejected for or discharged from a military position because of any physical, mental, or other medically related reason? |
| | | 127. | I am: ☐ right-handed ☐ left-handed |



INITIALS_____

## SECTION 6: OTHER MEDICAL *continued*

Y N ?

128. RESERVED

☐ ☐ 129. Have you taken any prescription or over-the-counter medications in the last 12 months? This would include vitamins, birth control pills, antacids, laxatives, aspirins, antihistamines, and weight reducing aids. If yes, list name and dosage.

| | NAME | DOSAGE | | NAME | DOSAGE |
|---|---|---|---|---|---|
| a) | | | d) | | |
| b) | | | e) | | |
| c) | | | f) | | |

☐ ☐ 130. Have you ever been absent from work due to stress?

☐ ☐ 131. Have you ever had any surgical operations? If yes, list the type of surgery and when it was performed.

| | TYPE OF SURGERY | DATE OF SURGERY |
|---|---|---|
| a) | | |
| b) | | |

☐ ☐ 132. Have you ever been hospitalized (at least overnight)? If yes, list the year, your age, reason and length of stay. Use section 7 if more than 2.

| | YEAR HOSPITALIZED | AGE | REASON | LENGTH OF STAY |
|---|---|---|---|---|
| a) | | | | |
| b) | | | | |

Y N ?

☐ ☐ 134. Are you currently limited by any temporary condition (e.g., broken bone, pregnancy, recovery from surgery)? If yes please describe in Section 7.

☐ ☐ 135. Have you ever had any doctor-imposed activity restrictions? If yes, please describe in Section 7.

☐ ☐ 136. Have you ever been to a doctor for back/neck pain or problems?

☐ ☐ 137. Have you ever been off work because of back/neck pain or problems?

☐ ☐ ☐ 138. Is there any history of heart disease in your immediate family?

☐ ☐ ☐ 139. Do any other diseases run in your family? Please list:

☐ ☐ ☐ 140. Do you or anyone in your family have high cholesterol?

☐ ☐ 141. Do you currently have a cold/cough, or have you had either in the last two weeks?

☐ ☐ 142. Have you missed more than five (5) days from work due to medical reasons in the past 12 months?

## SECTION 7: ADDITIONAL EXPLANATIONS AND SIGNATURE

Briefly explain any items marked "Yes" in Section 6. In addition, describe anything else which you feel may be important in your medical history, including any condition(s) not specifically referred to in the preceding questions. Use the back of this page if more space is needed.

| ITEM # | EXPLANATION | ITEM # | EXPLANATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## SECTION 8: CERTIFICATION

I hereby certify that all statements made in this New Patient Medical History Statement are true and the questions have been answered fully, completely and without omission. I understand that any misstatement or omission of a material fact may subject me to disqualification or dismissal.

| SIGNATURE IN FULL | DATE |
|---|---|
| | |



INITIALS_____