MORENO VALLEY COLLEGE
LAW ENFORCEMENT TRAINING PROGRAMS
16791 Davis Ave. #222
Riverside, CA. 92518
Phone: (951) 571-6316

HEALTH HISTORY AND PHYSICAL EXAMINATION
(Fill out History portion BEFORE visiting your physician)

NAME: _____ _____ _____
Last First Middle Sex Today's Date

ADDRESS: _____
Number Street City Zip Code

PHONE: (___)_____ HEIGHT: ____ft.____in. WEIGHT: _____lbs. AGE: _____

BIRTHDATE: _____ SOC. SEC. NUMBER: _____

DIRECTIONS: Please fill out this form as completely as possible. If you have any questions, DO NOT GUESS. Ask your physician for assistance.

I. Personal Health History and Risk Factors
Give the date, address, and physician who gave your last physical examination:

_____
_____

Characterize your present health status (check one)

Excellent _____ Good _____ Fair _____ Poor _____

A. CARDIOVASCULAR HEALTH
Have you ever had:
Rheumatic Fever _____ Diabetes _____
Heart Murmur _____ Dizziness or Fainting Spells _____

Answer the following questions YES or NO:
Has a doctor ever said that your blood pressure was too high or too low? _____
Do you ever have pain in your heart or chest? _____
Are you often bothered by a thumping or racing of the heart? _____
Do you ever notice skipping of your heartbeat? _____
Are your ankles ever badly swollen? _____
Has a doctor ever said you had or have heart trouble? _____
Do you suffer from frequent cramps in your legs? _____
Do you often have difficulty breathing? _____
Do you get out of breath long before anyone else? _____
Do you sometimes get out of breath when sitting still or sleeping? _____

B. GENERAL HEALTH

Have you ever had:

Polio _____
Asthma or Lung Disease _____
Injuries to back, arms, legs or joints _____
Scarlet Fever _____
Meningitis or Encephalitis _____
Pneumonia _____
Pleurisy _____
Hepatitis (jaundice) _____
Tuberculosis _____
Rheumatoid Arthritis _____
Kidney Disease _____
Chronic Intestinal Disease _____
Allergic Diseases _____
Hearing Difficulties _____

List Operations: _____

List Major Injuries: _____

List Unconsciousness for any reason: _____

Answer the following questions YES or NO:

Do you now have or have you recently had:

Any significant vision or hearing problems? _____
A history of anemia or bleeding tendency, or poor healing of cuts or wounds? _____
A chronic, recurrent or morning cough? _____
Any episode of coughing up blood? _____
Swollen, stiff or painful joints? _____
Pain in your legs after walking short distances? _____
Back pain? _____
Numbness in arm or leg? _____
Nausea? _____
Bowel or Kidney/Urine problems? _____
Stomach or intestinal problems? _____
Migraine or recurrent headaches? _____
Frequent colds or sore throat? _____
Skin problems? _____
Increased anxiety or depression? _____
Problems with recurrent fatigue, trouble sleeping, or increased irritability? _____

Are you taking any prescribed medications? _____
If Yes, List: _____
_____

Do you take any self-prescribed medications or dietary supplements? _____
If Yes, List: _____
_____

Do you have dentures or any removable dental fixtures? _____
If Yes, Describe: _____
_____

C. HEART DISEASE RISK FACTORS

1. Family History

Have any of your immediate blood relations had: (include parents, siblings, aunts, uncles, and grandparents, but exclude cousins and half relations).

Heart attacks or strokes under the age of 60 _____
High blood pressure _____
Heart operations _____
Diabetes _____

2. SMOKING

	YES	NO	
Do you smoke	( )	( )	
Cigarette	( )	( )	How many per day? _____ How many years? _____
Cigar	( )	( )	How many per day? _____ How many years? _____
Chew	( )	( )	How many times a day? _____ How many years? _____

How old were you when you started? _____
If you have stopped, when did you? _____
Why did you stop? _____

3. DIET AND WEIGHT

What is a good weight for you? _____
What is the most you have ever weighed? _____
When? _____ Weight one year ago? _____
Weight at age 21? _____
Is your present weight relatively stable? _____
Do you have trouble keeping your weight stable? _____
Are you presently on a diet? _____
Is the diet supervised by a physician? _____
If dieting, describe: _____
_____

Do you eat fresh or frozen fruits _____ and vegetables _____ daily?
If NO, why not? _____
Do you eat three meals per day? _____
How many eggs do you eat per week? _____
How many times per week do you eat: Beef? _____ Pork? _____ Fish? _____
Fowl? _____ Fried Foods? _____ Desserts? _____
How many glasses of milk do you drink daily? _____
Is it: Homogenized? _____ Skim? _____ Low-fat? _____ Buttermilk? _____
How much coffee (decaffeinated excluded) do you drink daily? _____
How much tea or cola do you drink daily? _____

4. PHYSICAL ACTIVITY

If employed, rate the physical activity level of your occupation:
Sedentary _____ Light _____ Moderate _____ Heavy _____ Hours per day _____

Are you currently involved in regular exercise program or recreational physical activity? _____
Describe: _____
_____
How many time per week? _____ minutes per day? _____

Rate your level of exercise and/or physical activity on a scale of 1-5 (including very strenuous) for each age range through your present age:
15-20 _____ 20-30 _____ 30-40 _____ 40-50+ _____
Did you participate in high school or college athletics? If so, which ones? _____
_____
_____

Do you have negative feelings toward, or have you had any bad experiences with physical activity, or physical activity programs? If yes, please explain _____
_____
_____

Do you start exercise programs, but are unable to stick with them? _____
Is competition a necessary ingredient for your exercise program? _____
Are you able to exercise alone? _____
Is a group situation necessary for you to maintain an exercise program? _____

Characterize your present "physical fitness" level (check one)
Excellent _____ Good _____ Fair _____ Poor _____

In consideration of being accepted into the Regular Basic Course, I certify that I have read and accurately completed this health form. I also declare that I have no concerns about my health that would affect my participation in a program of graded exercise testing or physical exercise. I will furnish this questionnaire to my physician.

_____ _____
Signature Date Signed

II. PHYSICIAN'S PHYSICAL EXAMINATION REPORT
(To be completed by the physician)

Name: _____ _____
Last First Middle Today's Date

Age: _____ Weight: _____ Height: _____

Pulse Rate (resting): _____
Blood Pressure (seated) left arm _____ right arm _____
Vision:
Without glasses: R _____ L _____
With glasses: R _____ L _____
Health History (pertinent comments): _____
_____
_____
_____

	Normal	Abnormal	Comments
HEAD			
Eyes			
Pupils			
Ocular Motion			
Ears			
Nasal Cavity			
Mouth			
Teeth			
Tongue			
Tonsils			
NECK			
Thyroid			
Cervical Nodes			
CHEST			
Lungs			
Heart			
Sounds			
ABDOMEN			
Masses			
Bowel Sounds			
HERNIA			

	Normal	Abnormal	Comments
MUSCULOSKELETAL			
Cervical Spine			
Thoracic Spine			
Lumbar Spine			
Shoulders			
Elbows			
Hips			
Knees			
Ankle			
Hands			
Feet			
Other Joints			
NEUROLOGICAL			
Reflexes			
Romberg			
Tandom Walk			
Finger to Nose			
Other			
SKIN			
Scars			

Patient Name: _____
Last First Middle

I have examined the above applicant and have found him/her to be medically qualified to participate in a program of physical exercise, including the graded exercise testing evaluation of the Regular Basic Course. Physical exercises include graduated sit-ups, leg raises/spreads, push-ups, ¼- to 6-mile runs, wind sprints, pull-ups, squat thrusts, abdominal curls, and rope climb. I have also discussed with the applicant any health concerns documented on the consent form. Any exercise limitations are listed below.

Limitations: _____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Examining Physician (printed name) Phone Number

Address: _____
Number Street City Zip

_____ _____
Signature Date of Exam