PART A - MEDICAL HISTORY

Please print. All information is to be filled in by enrollee and taken to physician's office.

Social Security # _____

Name _____

Date of Employment _____

Duties _____

Parish _____

❒ Male ❒ Female

❒ Single ❒ Never married

❒ Married ❒ Divorced ❒ Widowed

❒ Petition for divorce Date (MM/DD/YYYY) _____

THE FOLLOWING STATEMENTS MUST BE READ, SIGNED BY THE ENROLLEE, AND NOTARIZED:

I certify that all information that I provide is accurate and complete. I understand that any misrepresentation or failure on my part, intentional or unintentional, to fully disclose any information may be grounds for disqualification or discharge from employment and denial of benefits from insurance coverage and the Sheriffs' Pension Fund. I am aware that if I do not provide a full and accurate disclosure of all information requested, or intentionally make any false statements with respect to my application and the enrollment process, I may be guilty of perjury and/or false swearing and subject to prosecution therefore.

I agree to all examinations and tests deemed necessary and authorize any medical information to be furnished that the employer, the insurer, or the Sheriffs' Pension Fund shall deem necessary. I understand that all medical information provided to the Sheriffs' Pension Fund will be maintained in a confidential manner and will be used only by the Board of Trustees and appropriate Pension & Sheriff's Office staffs for making determinations with respect to preexisting conditions or application for disability benefits. I understand that I will be required to sign an exclusion of preexisting conditions, thereby disqualifying me from retirement benefits based upon that condition(s).

I understand that if the enrollment process is not completed within six (6) months from the date of my employment, vesting for disability benefits will not begin until the enrollment process has been completed.

_____
Signature of Enrollee

Sworn and subscribed before me this _____ day of _____ , _____

_____
Notary Public

_____ Parish Sheriff's Office

HAVE YOU EVER BEEN: Mark an X in the space to indicate yes.
Rejected/discharged for medical reasons for:
_____ Military Service? _____ Employment? _____ Insurance policy or rated? _____ Membership in SPF?

EXPLAIN ANY ITEMS CHECKED _____

TO DETERMINE PREEXISTING CONDITIONS, HAVE YOU EVER HAD A WORK-RELATED INJURY? _____ Yes _____ No

If yes, give date and explain _____

MEDICINES - Mark an **X** in the space to indicate medicines you have ever taken or are now taking

Now	Past		Now	Past		Now	Past	
____	____	Blood Thinners	____	____	Heart Medicine	____	____	Sedatives
____	____	Cortisone-type Drugs★	____	____	Blood Pressure Medicine	____	____	Tranquilizers
____	____	Steroids★	____	____	Insulin	____	____	Other Medications
____	____	Dilantin/Anticonvulsants						_____

★ **Specify reason for use of the medication(s).**

_____

List dosage and frequency of medicines you are currently taking _____

_____

List medicines you are allergic to _____

_____

LIFETIME HEALTH HISTORY: MARK AN **X** IN THE SPACE NEXT TO ANY OF THE FOLLOWING TO INDICATE YOU NOW HAVE OR HAVE EVER HAD:

_____ Arthritis
_____ Asthma
_____ Back trouble
_____ Bleeding from rectum
_____ Blood in stool
_____ Blood pressure problems
_____ Cancer (Indicate type)
_____
_____ Carpal tunnel syndrome
_____ Diabetes
_____ Emphysema
_____ Epilepsy
_____ Encephalitis
_____ Glaucoma
_____ Heart trouble
_____ Hematuria
_____ Hepatitis
_____ HIV
_____ Injury
_____ Kidney trouble
_____ Leukemia
_____ Liver trouble
_____ Lung trouble
_____ Migraine headaches
_____ Multiple Sclerosis
Muscular Dystrophy
_____ Muscular weakness
_____ Osteomyelitis
_____ Paralysis of a body part
_____ Polio
_____ Positive TB Test
_____ Rheumatic Fever
_____ Seizures
_____ Sickle Cell Anemia
_____ Spinal meningitis
_____ Stomach trouble
_____ Stomach ulcer
_____ Stroke
_____ Surgery (indicate type)
_____
_____ Thyroid trouble
_____ TMJ trouble
_____ Too much sugar in system
_____ Tuberculosis
_____ Varicose veins
_____ Venereal disease (indicate type)
_____
_____ Vomiting blood
_____ Other
_____
_____

MENTAL HEALTH - Have you ever been **tested or treated** for: Mark an **X** in the space to indicate yes.

_____ Anxiety _____ Nervousness _____ Schizophrenia _____ Insomnia
_____ Depression _____ Paranoia _____ Stress _____ Other_____

WOMEN ONLY

Date of last Pap smear:_____ Date of last mammogram:_____

Results: _____ Results: _____

USE THE SPACE PROVIDED BELOW TO EXPLAIN ITEMS CHECKED IN HEALTH AND MENTAL HISTORY. GIVE COMPLETE DETAILS; INCLUDING ALL ACCIDENTS, ILLNESSES, INJURIES, SURGERIES, HOSPITALIZATIONS.

DATES	PHYSICIAN	REASON / CAUSE	TREATMENT RECEIVED	OUTCOME

PHYSICIANS - Include name, address, and phone number of physician(s) for the last 10 years.

_____

_____

	Now	Past		Now	Past
TOBACCO					
Use tobacco in any form	_____	_____	Treated for tobacco-related condition	_____	_____
DRUGS					
Illegal use of controlled drugs	_____	_____	Treated for drug problem	_____	_____
ALCOHOLIC BEVERAGES					
Use alcoholic beverages of any kind	_____	_____	Treated for alcohol problem	_____	_____

PART B - PHYSICAL EXAMINATION

Enrollee's Name _____ Parish _____

PHYSICAL EXAMINATION - To be completed by physician performing examination. Indicate **every** item which is not within normal limits by placing an **X** in space provided. Male and female enrollees must have Genitourinary, Breast, and Rectal Exam.

I. GENERAL

Posture _____
Gait _____

II. SKIN

Color _____
Texture _____
Sweaty _____
Scars _____
Eruptions _____
Ulcers _____
Petechiae _____

III. HEAD

Shape _____
Hair _____
Masses _____
Tenderness _____
Bruit _____
Sinus _____

IV. EARS

External _____
Pinna _____
Canal _____
Drum _____

V. EYES

Muscles _____
Lids _____
Sclera _____
Conjunctivae _____
Cornea _____
Pupils _____
Fundi _____
  Macula _____
  Disk _____
  Arteries _____
  Veins _____
  Exudate _____

VI. MOUTH/THROAT

Lips _____
Breath _____
Mucosa _____
Dentures _____
Teeth _____
Tongue _____
Gingiva _____
Floor _____
Palate _____
Pharynx _____
Tonsils _____
Larynx _____

VII. NOSE

Septum _____
Obstruction _____
Mucosa _____
Sinus _____

VIII. NECK

Thyroid _____
Trachea _____
Veins _____
Masses _____
Bruit _____
Carotid _____
Spine _____
Range of Motion _____

IX. LUNGS

Expansion _____
Breath Sounds _____
Rales _____
Wheezes _____
Rubs _____
Rhonchi _____
Respiratory rate _____

X. HEART

Rate _____
Rhythm _____
Thrills _____
Rubs _____
Murmurs _____
Gallops _____

XI. BREASTS

Nodes _____
Discharge _____
Nipple _____
Areola _____
Symmetry _____
Consistency _____
Scars _____
Masses _____
Implants _____

XII. ABDOMEN

Contour _____
Tenderness _____
Masses _____
Hernia _____
Liver size _____ cm
Liver edge _____
  Smooth _____
  Irregular _____
  Nodular _____
Spleen size _____
CVA tenderness _____
Rebound _____

XIII. FEMALE GENITO-URINARY

Labia _____
Clitoris _____
Bartholin's gland _____
Urethra _____
Perineum _____
Introitus _____
Vagina _____
Cervix _____
Uterus _____
Adnexa _____
Cul-de-sac _____
Discharge _____

XIV. MALE GENITO-URINARY

Penis _____
Meatus _____
Epididymis _____
Varicocele _____
Testicles _____
Discharge _____
Hernia _____
Prostate _____
Scars _____

XV. RECTAL

Anus _____
Sphincter _____
Hemorrhoids _____
Mucosa _____
Masses _____
Pilonidal _____
Fissure _____

XVI. NEUROLOGIC

Grasp _____
Plantar _____
Biceps _____
Triceps _____
Knee _____
Ankle _____
Romberg _____
Babinski _____
Coordination _____
Tremor _____
Vibratory _____
Cranial Nerves _____
Sensory _____

XVII. MUSCULOSKELETAL

Shoulder _____
Arm _____
Elbow _____
Radial Pulse _____
Wrist _____
Hand _____
Fingers _____
Fingernails _____
Spine _____
  Kyphosis _____
  Lordosis _____
  Scoliosis _____
Hip _____
Leg _____
Knee _____
Ankle _____
Foot _____
Pedal pulse _____
Toes _____
Toenails _____
Joints _____

XVIII. EXTREMITIES

Clubbing _____
Cyanosis _____
Edema _____
Veins _____
Stasis _____
Ulceration _____
Hair distribution _____

XIX. EMOTIONAL

Speech _____
Affect _____
Orientation _____
Memory _____

(Continued on reverse side)

Height _____ Weight _____ Temperature _____

Blood Pressure _____ If 140/90 or above, recheck in 5 minutes _____

Resting Pulse _____

Vision Uncorrected _____ Corrected _____ Blind R _____ L _____

Hearing (20 feet) _____ Note any hearing impairment R _____ L _____

LABORATORY INFORMATION - Attach Reports

CBC

Routine urinalysis

Chemistry panel including lipid & liver panels (fasting)

Urine drug screen - To include amphetamines barbiturates, benzodiazepines, cocaine, marijuana, opiates, phencyclidine

Indicate Results and Attach Reports

VDRL _____

TB Skin Test _____
(If positive, submit chest x-ray report)

HIV _____

Hemmocult _____

Remarks on laboratory results _____

List every item that needs explanation from enrollee's history, physical examination and laboratory results.

PROBLEM	PLAN

From your examination of _____, do you consider enrollee to be in good physical and mental condition and capable of performing duties with no limitations? _____

With limitations or with deficiency? _____ Disapproved? _____

List deficiencies or reasons for disapproval _____

This examination and resulting information truly depict the condition of this enrollee on the _____ day of _____, _____. **I attest that I have reviewed examination and laboratory results with this enrollee.**

_____ _____

Examining Physician's Signature

Typed or Printed Name of Physician