



Public Safety Training Center
Health History Statement
 (Last Ten Years)

The information you provide in this statement will be used to assess your medical qualifications to participate in the Yuba College Basic *or* Modular Format Academy Physical Conditioning Program. All information will be kept confidential.

Please fill out the statement carefully and thoroughly.

NAME: _____

DEPARTMENT/ACADEMY: _____

BIRTHDATE: _____ TODAY'S DATE: _____

Please answer all of the following. Check YES or NO on each question.

Do you now have or have you ever had any of the following?

	YES	NO		YES	NO
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Serum Lipids (fats—i.e. cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>			

Please Specify: _____

Have you ever experienced any of the following? For each condition checked, indicate whether the condition was diagnosed and whether the condition was associated with exercise or physical work.

		Diagnosed?		Associated with exercise or physical work?	
YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

Have you ever taken any of the following tests? If yes, indicate whether the results indicated any abnormalities.

		Any Abnormalities?	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

Has a blood relative ever been diagnosed as having any of the following? (Include parents, grandparents, aunts and uncles, brothers and sisters, and children, but exclude relatives by marriage and half relatives)

YES	NO		Mother	Father	Other
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Serum Liquids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer YES, NO, or other specified entry to the following questions.

Have you ever smoked cigarettes, cigars, or a pipe? YES NO

If "YES," state the year you started. _____

Do you smoke presently?

If you did or do smoke cigarettes, how many per day? _____

If you did or do smoke cigars, how many per day? _____

If you did or do smoke a pipe, how many pipefuls per day? _____

If you quit smoking, please state the year you quit. _____

Do you ever drink alcoholic beverages?

If yes, what is your approximate intake of these beverages?

	None	Occasional	Often	How many drinks per week?
Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hard Liquor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

List any traumatic injuries you have experienced to your bones or soft tissue (include any disabling back problems you have had) and the approximate date of the injury.

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

List any illnesses you have had which required you to take more than one week of sick leave and the approximate date of the illness.

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

List any operations you have had, including approximate dates.

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

List any medications you are now taking (include self-prescribed medications and dietary supplements).

Name of Medication Day (See labels for prescription medications)	Date Started	Dosage	Dosage Per
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any athletic or other physical activities that you regularly engage in. Specify for each the frequency, intensity, and duration of your involvement.

	Activity	Frequency	Intensity	Duration
<i>Example:</i>	<u>Bicycling</u>	<u>3 times a wk.</u>	<u>10 miles</u>	<u>Past 18 months</u>

_____	_____	_____	_____
_____	_____	_____	_____

List anything else that you feel may be important in your medical history, including any conditions not specifically referred to in the preceding questions.

I hereby certify that all statements made in this Health History Statement are accurate and complete.

Signature in full: _____ Date _____