Port St. Lucie Police Department
Physical Examination

To be completed by a physician

Applicant's Name: _____ D.O.B.: _____ Age: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

	Normal	Abnormal Finding	Initials
MEDICAL			
Appearance			
Eyes, Nose			
Throat			
Lymph Nodes			
Heart			
Pulse			
Abdomen			
Genitals (Males)			
MUSCULOSKETAL			
Neck			
Back			
Shoulders			
Arms			
Elbows			
Forearms			
Wrists			
Hands			
Hips			
Thighs			
Knees			
Legs			
Ankles			
Feet			

Assessment of Physician

I hereby certify this examination, that was performed by myself, or my designee, with the following conclusion(s):

_____ Cleared without limitations
_____ Cleared with limitations
_____ Not cleared for physical fitness or exercise

Signature of Physician: _____ Date: _____

Personal Physical Evaluation

For Participation

Applicants Name: _____ Sex _____ Age _____ DOB _____

Family Physician's Name: _____ Office Phone #: _____

Medical History:

1.	Have you had a medical illness or injury since your last check up?	Yes	or	No
2.	Do you have an ongoing chronic illness?	Yes	or	No
3.	Have you been hospitalized overnight?	Yes	or	No
4.	Have you ever had surgery?	Yes	or	No
5.	Have you used or are you using an inhaler?	Yes	or	No
6.	Are you currently taking any medication?	Yes	or	No
7.	Do you have any allergies?	Yes	or	No
8.	Have you ever had a rash or hives after exercise?	Yes	or	No
9.	Have you ever passed out, been dizzy, or had chest pain after exercise?	Yes	or	No
10.	Have you ever had racing of your heart or skipped a heartbeat?	Yes	or	No
11.	Have you ever had high blood pressure?	Yes	or	No
12.	Have you ever been told you have heart problems of any type?	Yes	or	No
13.	Do you get tired more quickly than your friends during exercise?	Yes	or	No
14.	Has any family member died from heart problems before age 50?	Yes	or	No
15.	Has a physician ever denied you from participating in exercise?	Yes	or	No
16.	Have you ever had a head injury or concussion?	Yes	or	No
17.	Have you ever become unconscious for no reason at all?	Yes	or	No
18.	Have you ever had a seizure?	Yes	or	No
19.	Do you have frequent or severe headaches?	Yes	or	No
20.	Have you ever had numbness in your arms, legs, or feet?	Yes	or	No
21.	Have you ever had a pinched nerve?	Yes	or	No
22.	Have you ever become ill from exercising in the heat?	Yes	or	No
23.	Do you have trouble breathing during exercise?	Yes	or	No
24.	Do you have asthma?	Yes	or	No
25.	Do you wear any special devices to exercise (knee brace)?	Yes	or	No
26.	Do you have any other medical concerns we need to know about?	Yes	or	No
27.	Do you feel stressed out about any situation?	Yes	or	No
28.	Have you ever had a tetanus shot? When/Year _____	Yes	or	No