OKLAHOMA POLICE PENSION AND RETIREMENT SYSTEM

PHYSICAL-MEDICAL EXAMINATION

INSTRUCTION TO THE PHYSICIAN

The following History and Physical with Lab Data are required by each applicant:

1. Complete medical and surgical history with dates.
2. Complete physical exam. ***Stool guaiac results may be obtained from take-home kit.***
3. Visual testing: With and without correction.
   - Binocular Vision
   - Color Vision
4. Audiometric testing with decibel level.
5. Blood work:
   - A. Comprehensive Metabolic Profile
   - B. Cholesterol
   - C. GGTP
   - D. Complete Blood Count
   - E. RPR
   - F. Hepatitis B Surface Antigen – HBSAG
   - G. Hepatitis B Core Antibody – HBCAB
   - H. Hepatitis C Antibody – HCV
   - I. Human Immunodeficiency Virus - HIV
6. Urinalysis with microscopic.
7. X-rays - Chest (PA), lumbar spine (obtain only if history of back problems or surgery).
8. T.B. Skin Test.
9. Pulmonary Function Test.
10. Exercise Tolerance Test (Bruce Protocol) with interpretation.
11. Complete knee examination form if history of knee surgery or significant injury.
12. Urine drug test must meet NIDA Standards.

FULL NAME _____ SSN _____ DATE _____

SEX _____ RACE _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____ PHONE (_____) _____

CITY, STATE, ZIP _____ PHYSICIAN _____

A. Have you ever:	YES	NO
1. Received compensation for injury?	_____	_____
2. Received a disability pension?	_____	_____
3. Received medical discharge from armed forces?	_____	_____
4. Been rejected for military service for medical reasons?	_____	_____
5. Been hospitalized?	_____	_____
6. Been operated on?	_____	_____
7. Been rejected in any medical examination?	_____	_____
8. Had allergic reactions to drugs, medications, blood transfusions, insect bites?	_____	_____

B. Have you ever had disease or injury to: (Circle affirmative items)

1. Head, ears, eyes, nose, throat?
2. Neck, back, hips, arms, legs, hands, feet?
3. Joints: shoulder, elbows, knees, wrist, ankles?
4. Heart: chest pain, palpitations, fainting, shortness of breath with exertion, sudden shortness of breath at night, feet swell, high blood pressure? History of Rheumatic fever or heart murmur, varicosities, deep leg pain (thrombophlebitis), heart attack, or stroke?

5. Lungs: Unusual shortness of breath, sputum production, coughed up blood, chest pain, wheezing, recurrent infections, history of asthma, history of smoking cigarette_____, pipe_____, cigar_____, other? How many per day?_____ For how many years?_____
6. Breast: Pain, masses, nipple discharge? History of trauma, self-breast exam and/or history of mammograms?
7. GI: Weight change, nausea or vomiting, vomiting blood, heart burn, abdominal pain, diarrhea or constipation of chronic or unusual character? History of ulcers, rectal bleeding, jaundice, laxative use/abuse?
8. GU: Pain when you urinate, blood colored urine, frequency or urgency to urinate? History of kidney stones, recurrent urinary tract infections, venereal diseases (syphilis, gonorrhea)?
9. Genital Tract:

   Female: Age of Menses _____; # of days between periods _____; Date of last regular period _____; History of severe pain during menstruation? Any history of unusual bleeding between periods? History of vaginal discharge? # of pregnancies _____; # of abortions or miscarriages _____; # of deliveries _____; Types of contraceptive currently used _____; date and result of last pap smear?_____. ***New pelvic exam must be completed if last negative pap smear was performed more than two years ago.***

   Male: Penile pain, discharge or skin lesions? Testicular pain or masses. History of prostate problems, hernias? History of vasectomy?
10. History of anemia, swollen and/or sore lymph nodes, easy or spontaneous bruising, excessive bleeding? History of any type of cancer?
11. History of retarded growth or development? Temperature intolerance, goiter, increased thirst, appetite, or frequency to urinate? History of diabetes, gout, recurrent skin rashes, unusual loss of hair?
12. History of tremor, paralysis, imbalance, muscle weakness or low sensitivity with the sense of touch? History of seizure disorder?
13. History of nervousness, anxiety, irritability? History of depression or suicide? History of psychiatric/psychological evaluation and/or treatment? History of drug or alcohol abuse?
14. History of Hepatitis B, Hepatitis C, HIV or AIDS?

C. Family medical history and any descriptive comments on positively answered question(s) should be completed below.

D. All affirmative answered responses to the health screen if significant or pertinent to current health status of the applicant should be identified and outlined as to the time of onset, duration, location, aggravating or alleviating symptoms and any associated symptoms that are characteristic of the problem.

I certify that the above health information is complete and true to the best of my knowledge. I authorize the medical examiner for the participating municipality to investigate any and all statements of health made herein.

_____ _____

Signature of Examinee Date

Comments: _____

_____

_____

_____

_____

_____

_____

PHYSICAL EXAM AND LABORATORY ASSESSMENT FORM

Name: _____ City: _____ Date: _____

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

		Normal	Comments
1)	Integument		
2)	Heent		
3)	Breast		
4)	Chest		
5)	Heart		
6)	Abdomen		
7)	Genitalia		
8)	Prostate-Specific Antigen (PSA) Test ***(Males Only)***		
9)	Stool Guaiac Results		
10)	Musculoskeletal		
11)	Neurologic		

Laboratory Results

1) Visual Acuity: Uncorrected R_____/ L_____ Binocular Vision _____
Corrected R_____/ L_____ Color Vision _____

2) Audiometric: (500) ___/___ (1000) ___/___ (2000) ___/___ (3000) ___/___ (4000) ___/___ (6000) ___/___

3) X-ray A) PA Chest: _____
B) Lumbar Spine Series _____
(Obtain only if history of back problem)

4) Please submit copy of:

A. Comprehensive Metabolic Profile
B. Cholesterol
C. GGTP
D. Complete Blood Count
E. RPR
F. Hepatitis B Surface Antigen HBSAG
G. Hepatitis B Core Antibody - HBCAB
H. Hepatitis C Antibody – HCV
I. Human Immunodeficiency Virus – HIV
J. Urinalysis
K. Drug Screen

5) PPD Positive ( ) Negative ( )

Examiner's Signature _____

SPIROMETRY REPORT

PHYSICIAN: _____ TEST #: _____

NAME: _____ DATE: _____

AGE: _____ HEIGHT: _____ (cm) WEIGHT: _____ (lbs) RACE: _____ SEX: _____

DIAGNOSIS: _____

_____ ASTHMA	_____ TUBERCULOSIS	HISTORY:
_____ BRONCHITIS	_____ HYPERTENSION	_____ MORNING COUGH
_____ EMPHYSEMA	_____ CHEST PAIN	_____ SPUTUM COLOR
_____ LUNG CANCER	_____ OTHER	_____ SPUTUM AMOUNT

SMOKING:

A. Never used

B. Used to smoke, stopped _____ years ago.

C. Used to smoke _____ pack/day for _____ years.

D. Continue to smoke.

E. Have smoked _____ pack/day for _____ years.

F. Smoke only a pipe or cigar.

MEDICATION NOW TAKING:

_____

_____

_____

_____

TEST	PREDICTED	ACTUAL	%
Forced Vital Capacity (FVC) (L)			
Forced Expiratory Volume (FEV_1) (L)			
$\frac{FEV_1}{FVC}$			
Forced Expiratory Flow (FEF_{25-75}) (L/Sec.)			

INTERPRETATION:

NAME: _____

KNEE EXAMINATION

RANGE OF MOTION:

Flexion: _____ Extension: _____

Crepitus with range of motion testing: Yes: _____ No: _____

DEFORMITIES:

Swelling/Effusion: _____

With leg in full extension, circumference of thigh 7 cm and 20 cm proximal to superior pole of patella:

L:		
R:		

TESTS:

McMurray's (medical meniscus): _____

Internal Rotation (lateral meniscus) with the foot internally rotated, movement from full flexion to extension: _____

Medial collateral ligament: _____

Lateral collateral ligament: _____

Anterior drawer (anterior cruciate ligament): _____

Patellar apprehension: _____

VMO on injured side compared to other: _____

Hop on each leg: _____ Squat: _____

Knee pain on rotation of hips and shoulders with feet together:

Yes: _____ No: _____

Knee pain on rotation of hips and shoulders with feet crossed:

Yes: _____ No: _____

X-rays, 3 views - AP, lateral and sunrise: _____

INFORMED CONSENT FOR TREADMILL EXERCISE TEST OF PATIENTS

In order to evaluate the functional capacity of my heart, lungs, and blood vessels, I hereby consent, voluntarily, to perform an exercise test. I understand that I will be questioned and examined by a doctor, and have an electrocardiogram recorded to exclude any apparent contraindications to testing. Exercise will be performed by walking on a treadmill, with the speed and grade increasing every three minutes, until limits of fatigue, breathlessness, chest pain, and/or other symptoms occur to indicate that I have reached my limit. Blood pressure and electrocardiogram will be monitored during the test. The test may be stopped sooner than my own limit if the technician's observations suggest that it may be unnecessary or unwise to continue.

The risks in performing this test are the risks of physical exercise and include irregular, slow and very rapid heartbeats, large changes in blood pressure, fainting, and very rare instances of heart attack. Every effort will be made to minimize these by the preliminary examination and by observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations as they arise.

The information obtained will be treated as confidential and will not be released to anyone without my express written consent. The information may, however, be used for statistical or scientific purpose with my right of privacy retained.

I have read the above, understand it, and all questions have been satisfactorily answered.

Patient's Signature: _____

Witness: _____

Date: _____

EXERCISE TOLERANCE TESTING WORKSHEET

Name: _____ Date: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

MPHR 100% _____ 85% _____ Medications: _____

HR	BP	ST DEPRESSION	OTHER EKG CHANGES	SYMPTOMS	
Sit _____					
Standing _____					
Hypervent.					
Minutes					
1 _____					STAGE 1
2 _____					1.7 MPH
3 _____					10% GRADE
4 _____					STAGE 2
5 _____					2.5 MPH
E 6 _____					12% GRADE
X 7 _____					STAGE 3
E 8 _____					3.4 MPH
R 9 _____					14% GRADE
C 10 _____					STAGE 4
I 11 _____					4.2 MPH
S 12 _____					16% GRADE
E 13 _____					STAGE 5
14 _____					5.0 MPH
15 _____					18% GRADE
16 _____					STAGE 6
17 _____					5.5 MPH
18 _____					20% GRADE
IMMED. _____					
R 1 _____					
E 2 _____					
C 3 _____					
O 4 _____					
V 5 _____					
E 6 _____					
R 7 _____					
Y 8 _____					

TOTAL: _____ LAST STAGE: _____ TIME IN LAST STAGE: _____

POST-EXERCISE P.E.: _____ MHR: _____ % OF MHR: _____

MAX. SYSTOLIC B.P.: _____ ST: _____ DOUBLE PRODUCT: _____

VO_2: _____ R-WAVES: PRE: _____ POST: _____ RST: _____

FUNCTIONAL AEROBIC IMPAIRMENT: _____

INTERPRETATION:

AUTHORIZATION TO RELEASE MEDICAL/PSYCHIATRIC/PSYCHOLOGICAL INFORMATION

Patient's Name _____

Date of Birth _____

Social Security Number _____

TO WHOM IT MAY CONCERN:

I hereby request and authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to furnish to the Oklahoma Police Pension and Retirement System , the Retirement Board, and/or the participating municipality to which I am seeking employment and any representative thereof (collectively, the "System") any and all records, information and evidence in their possession regarding my injuries, medical history, physical condition, and psychiatric/psychological information, including information related to alcohol or drug abuse, both prior and subsequent to the date below until this authorization expires or until I revoke this authorization. Any or all of such health information is referred to in this authorization as my "protected health information" or "PHI."

Upon presentation of this authorization, or an exact photocopy thereof, you are directed (1) to permit the personal review, copying or photostatting of such records, information and evidence by the System or (2) to provide copies of such records to the System.

I further understand that, if my PHI is transmitted or maintained electronically (my "electronic PHI"), you or any agent or subcontractor that creates, receives, maintains, or transmits my electronic PHI will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of my electronic PHI, and you will ensure that any agent (including a subcontractor) to whom you provide my electronic PHI agrees to implement reasonable and appropriate security measures to protect my PHI.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

I hereby acknowledge that the information authorized for release may include information which may be considered information about a communicable or venereal disease, which may include, but is not limited to, a disease such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

I also acknowledge that the information that is used or disclosed pursuant to this authorization may be used or redisclosed by the System for purposes of eligibility and benefits determinations and, if presented at a Retirement Board meeting and/or hearing, the information may become part of a public record.

I understand that I may revoke this authorization at any time, in writing, except that revocation will not apply to information already used or disclosed in response to this authorization.

Unless revoked or otherwise indicated, this authorization will expire two years from date of signature.

I hereby release the System from any liability in connection with the release of information pursuant to this authorization.

Signature _____ Date _____