SCHEDULE "D"

MEDICAL QUESTIONNAIRE

Last Name _____ First Name _____

File Number _____

Address _____

Postal Code _____ Telephone _____

I) PERSONAL MEDICAL HISTORY

Have you ever suffered or do you currently suffer from the following problems or symptoms?
(If yes, fill out the appropriate boxes)

	Previously	Currently	Comments
Head, Nose, Mouth and Throat			
Frequent nose bleed			
Frequent nasal congestion			
Hoarseness without a cold			
Difficulty swallowing			
Loss of taste or smell			
Ears and Auditory Acuity			
Hearing loss			
Use of hearing aids			
Vertigo – dizziness			
Ringing in the ears			
Eyes and Vision			
Glaucoma			
Cataract			
Eye injury			
Eye irritation (itching)			
Eye surgery			
Wearing corrective glasses			
Wearing contact lenses			
Gastrointestinal System			
Persistent abdominal pain			
Vomiting blood			
Ulcer			
Hepatitis			
Jaundice			
Black stools - blood in stools			
Persistent constipation			
Persistent diarrhea			
Haemorrhoids			
Urinary System			
Kidney stones			
Kidney disease			
Blood in urine			
Frequent urination			
Cardiovascular System			
Chest pain or tightening			
Palpitations or irregular heartbeats			
High blood pressure			
Swollen legs (oedema)			
Heart murmur			
Vascular disease			
Heart disease (angina and/or heart attack)			
Pulmonary System			
Shortness of breath			
Persistent night sweats			
Morning cough with sputum			
Cough with blood			
Pneumonia			
Asthma			
Tuberculosis			
Emphysema			
Musculo-skeletal system			
Arthritis - Arthrosis			
Muscular or articular pain			
Bursitis or tendinitis			
Neck pain or cervical pain			
Pain or shoulder problems			
Pain or back problems			

	Previously	Currently	Comments
Pain in wrists – hands – elbows			
Pain or knee problems			
Pain in feet or ankles			
Psychological - Mood Disorder			
Drug or alcohol problem			
Suicide attempt			
Depression			
Anxiety			
Attention disorder			
Panic attack			
Claustrophobia			
Fear of heights			
Endocrine system - Metabolism			
Diabetes			
Hypoglycemia			
Thyroid disease			
Neurological System			
Headaches			
Convulsion, epilepsy			
Loss of consciousness - fainting			
Numbness - weakness in the limbs			
Tremor (shaking)			
Skin			
Eczema			
Skin rash			
Hives			
Infectious Diseases			
Aids or HIV positive			
Rheumatic fever			
Circulatory - Lymphatic System			
Anemia			
Hemorrhagic disease			
Blood transfusions			
Oncology (Cancer)			
Cancer (specify type)			
Surgery			
Radiotherapy			
Chemotherapy			
Male Reproductive System			
Testicular lump			
Female Reproductive System			
Breast or armpit lump			
Severe menstrual pain			
Date of last period:			
Other Conditions Specify:			

II) HOSPITALIZATION

Have you ever been hospitalized? (If yes, fill out the appropriate boxes)

	1st time	2nd time	3rd time
Reason (diagnosis)			
Date (month/year)			
Name of hospital			

III) COMPENSATION

Have you ever applied for or received benefits or compensation payments as a result of an injury, an illness, a disability or motor vehicle accident? (If yes, fill out the appropriate boxes)

Date (Month/Year)	Type of injury (Diagnosis)	Nature of treatment	Type of impairment
Comments:			

IV) ALLERGIES

Do you suffer from any allergies? No ❒ Yes ❒

Specify : _____

_____

_____

V) MEDICATION

Do you take any medication? No ❒ Yes ❒

Specify : _____

_____

_____

VI) FAMILY MEDICAL HISTORY

Diseases	Father	Mother	Brothers/Sisters
Heart disease			
Hypertension			
Pulmonary disease			
Asthma			
Diabetes			
Migraine			
Rheumatism – arthritis			
Depression – anxiety – suicide			
Alcoholism			
Cancer			
Other diseases (specify)			

VII) PERSONAL LIFESTYLE

1) Smoker : No ❒ Yes ❒ Number of cigarettes/day : _____

Former smoker : No ❒ Yes ❒ If yes, number of years : _____

2) Alcohol : No ❒ Yes ❒ Quantity :
- ❒ More than 2 glasses a day
- ❒ 1-2 glasses a day
- ❒ Occasionally

3) Tea-coffee : No ❒ Yes ❒ Number of cups/day : _____

4) Drugs : No ❒ Yes ❒ Specify : _____

5) What is your general stress level?

❒ None ❒ Low ❒ Average ❒ High ❒ Excessive

6) Do you exercise? No ❒ Yes ❒ Frequency
- ❒ Less than 1 hour a week
- ❒ 1 hour to 5 hours a week
- ❒ More than 5 hours a week

What type(s) of physical activities do you practice? _____

_____

_____

_____

_____

I attest that the above information is true to the best of my knowledge. I am aware that any false statement regarding the information provided in the questionnaire could cancel my request for application for admission to the École nationale de police du Québec.

_____ _____

Signature of applicant Date