SCHEDULE "D"

Medical Questionnaire

To the applicant: PLEASE GIVE DETAILS on positive answers in the questionnaire.
Incomplete information may cause a delay in the processing of your file.
To the medical examiner: check and comment the positive answers in a clear and relevant manner.

IMPORTANT – PLEASE READ BEFORE COMPLETING THIS QUESTIONNAIRE: The purpose of this medical examination is to determine if the applicant has a condition that could affect his ability to perform the tasks of the basic training program in police patrolling safely and efficiently, including firearms handling.

N.B. The masculine form used in this questionnaire includes the feminine.

1 Identification

File Number:

Last Name: _____ First Name: _____

Address: _____
(street) (apt.)

_____
(city) (province) (postal code)

Telephone: _____
(home)

_____
(work or cell)

Email: _____

Date of Birth: _____
(year) (month) (day)

Age: _____ Sex: M ☐ F ☐

Have you ever completed a medical questionnaire or undergone a medical examination for the École nationale de police du Québec?

Yes ☐ No ☐

Applicant's Initials:

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2 Personal Medical History

If the answer to any of the questions is "yes", please provide the requested information.

		Yes	No	No.	Comments
1 -	Have you ever been hospitalized? If yes, please give details.	☐	☐	1 -	Month/year:
					Reason:
2 -	Have you ever had surgery which resulted in permanent consequences and/or functional limitations? If yes, please give details.	☐	☐	2 -	Month/year:
					Reason:
					Describe the permanent consequences / limitations:
3 -	Do you **presently** receive medical treatment or do you take any medication? If yes, please give details.	☐	☐	3 -	Why?
					Type of treatment and/or medication:
4 -	Have you ever had temporary functional limitations? If yes, please give details.	☐	☐	4 -	Month/year:
					Description of the limitations:
5 -	Have you ever had a work accident that resulted in permanent functional limitations? If yes, please give details.	☐	☐	5 -	Month/year:
					Description of the accident:
					Length of time off work/studies:
					Description of the functional limitations:

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Comments:

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3	Review of the Systems	Have you ever received treatment or do you currently receive treatment for either of the following diseases? Check the answer, circle the disease, injury or symptom, and give details.

		Yes	No	No.	Comments
6 -	**Visual disorders:**	☐	☐	6 -	
	a) Glaucoma, cataract, retinal detachment blindness? If yes, please give details.				
	b) Do you wear corrective glasses or contact lenses?	☐	☐		
	c) Have you ever had eye surgery? If yes, please specify date: ____/____/____ year month day	☐	☐		
	d) Do you have any trouble differentiating colours?	☐	☐		
7 -	**Hearing disorders**: e.g., deafness, discharge, ringing in the ears, use of hearing aids? If yes, please give details.	☐	☐	7 -	
8 -	**Gastrointestinal disorders**: e.g., hepatitis, hernia, colitis, chronic diarrhea? If yes, please give details.	☐	☐	8 -	
9 -	**Heart problems**: e.g., angina, heart attack, palpitations, heart failure, heart murmur? If yes, please give details.	☐	☐	9 -	
10 -	**Blood vessel disorders**: e.g. varicose veins, swollen or cold hands or feet, blockage of the arteries, phlebitis, pulmonary embolism? If yes, please give details.	☐	☐	10 -	
11 -	**Lung and bronchial disorders**: e.g., asthma, chronic bronchitis, pneumonia, wheezing, frequent coughing, shortness of breath? If yes, please give details.	☐	☐	11 -	
12 -	**Sleep apnea**:			12 -	
	a) Have you ever been diagnosed with sleep apnea?	☐	☐		
	b) Have you ever suffered from high blood pressure?	☐	☐		

Applicant's Initials:

Comments:

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		Yes	No	No.	Comments
13 -	**Kidney or bladder disorders:** e.g. kidney failure, blood, proteins or sugar in urine?	☐	☐	13 -	
14 -	**Nervous system disorders**: e.g. convulsions, vertigo, epilepsy, paralysis, severe headaches, tremor, loss of consciousness, concussion, dyslexia or other cognitive disorders? If yes, please give details.	☐	☐	14 -	
15 -	**Mental health disorders**: e.g. insomnia, anxiety, depression, memory loss, phobia, panic disorder, psychosis, attention-deficit disorder? If yes, please give details.	☐	☐	15 -	Month/Year:
					Time off from work/studies? If yes, duration:
					Hospitalization?
					Medication:
16 -	**Musculo-skeletal disorders:**				
	a) joint pain, arthritis, muscle atrophy, amputation, stiffness or loss of strength in the shoulders, elbows, wrists, hands hips, knees, ankles, feet? If yes, please give details.	☐	☐	16a -	
	b) Difficulty walking on uneven surface, climbing stairs, standing in stairs, kneeling, making movements with wrists, arms? If yes, please give details.	☐	☐	16b -	
17 -	**Back and spine disorders**: e.g., back pain, herniated disk, difficulty bending, carrying heavy objects, turning or bending your neck forward or keeping your head in the same position for a long time? If yes, please give details.	☐	☐	17 -	Month/year:
					Description of the problem:
					Time off from work/studies? If yes, duration:
					Treatment:
18 -	**Skin/immune system disorders**: e.g., psoriasis, eczema, hives? If yes, please give details.	☐	☐	18 -	Treatment:
					Time off from work/studies? If yes, duration:
19 -	**Circulatory system disorder**: e.g., anemia, coagulation disorder, leukemia, etc.? If yes, please give details.	☐	☐	19 -	
20 -	**Endocrine system disorders**: e.g., thyroid, adrenal gland disorders? If yes, please give details.	☐	☐	20 -	
21 -	Have you ever received treatment or do you receive treatment for: If yes, please give details.			21 -	
	- Cancer?	☐	☐		
	- Hypertension?	☐	☐		
	- Allergies: medication, latex, food, others?	☐	☐		
	- Diabetes?	☐	☐		
22 -	Have you ever refused to undergo treatment or surgery that was recommended by a physician?	☐	☐	22 -	Month/year:
					Nature of treatment or surgery:

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Comments:

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4	Lifestyle	Please provide the requested information on positive answers

		Yes	No	No.	Comments
23 -	Do you take substances that could alter your judgement, vigilance, physical capacity or concentration at work? (e.g., alcohol, drugs, medication, energy drinks)	☐	☐	23 -	
24 -	Are you limited to work on a rotating or particular schedule? If yes, please give details.	☐	☐	24 -	

Comments:

IMPORTANT: READ AND SIGN

I agree to undergo a medical examination including laboratory tests, x-rays and other required testing. I authorize the medical examiner to forward the relevant findings of these exams to the École nationale de police du Québec and I also authorize that my entire file be transmitted to the health clinic of the School when required.

I have re-read my answers to each of the questions in this questionnaire and I certify that they are complete and true to the best of my knowledge. Any false statement regarding the provided information could cancel my application for admission to the École nationale de police du Québec.

_____ Signature of the applicant

_____/_____/_____ day month year

_____ Signature of the witness (M.D./nurse)