TROOPER APPLICANT MEDICAL QUESTIONNAIRE

rev.9/2026

(Note: This form must be filled out by the Trooper Applicant.)		
Date of last Medical Exam:	Date of Birth:	
Last Name:	First Name:	Middle Name:
Gender:	Age:	

For all sections below, please explain all "yes" answers in the open space provided and reference the question number.

Medicines & Allergies

1. Do you have any allergies? **Yes** ☐ **No** ☐
2. Do you carry an inhaler? **Yes** ☐ **No** ☐
3. Do you carry an Epi Pen? **Yes** ☐ **No** ☐
4. Do you take any prescriptions and/or over the counter medicines and supplements (herbal & nutritional)? **Yes** ☐ **No** ☐

General Questions

1. Have you ever had a seizure or been diagnosed with epilepsy? **Yes** ☐ **No** ☐
2. Do you have any ongoing medical conditions? **Yes** ☐ **No** ☐
3. Have you ever been admitted to the hospital? **Yes** ☐ **No** ☐
4. Have you ever had surgery? **Yes** ☐ **No** ☐

Heart Health Questions About You

1. Have you ever passed out or nearly passed out DURING or AFTER exercise? **Yes** ☐ **No** ☐
2. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? **Yes** ☐ **No** ☐
3. Does your heart ever race or skip beats while resting or during exercise? **Yes** ☐ **No** ☐
4. Has a doctor ever told you that you have any heart problems? **Yes** ☐ **No** ☐
5. Has a doctor ever ordered a test for your heart? **Yes** ☐ **No** ☐
6. Do you get lightheaded or feel more short of breath than expected during exercise? **Yes** ☐ **No** ☐
7. Have you ever had any heart surgery? **Yes** ☐ **No** ☐

Heart Health Questions About Your Family

1. Does anyone in your family have an irregular heartbeat? **Yes** ☐ **No** ☐
2. Has any family member / relative died of heart problems, unexpected or unexplained sudden death before age 50? **Yes** ☐ **No** ☐
3. Does anyone in your family have a heart problem, pacemaker, or defibrillator? **Yes** ☐ **No** ☐
4. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning? **Yes** ☐ **No** ☐
5. Do you or someone in your family have sickle cell trait or disease? **Yes** ☐ **No** ☐

Bone & Joint Questions
1. Have you ever had any broken or fractured bones or dislocated joints? **Yes** ☐ **No** ☐
2. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast or crutches? **Yes** ☐ **No** ☐
3. Have you ever had a stress fracture? **Yes** ☐ **No** ☐
4. Do you regularly use a brace, orthotics, or other device? **Yes** ☐ **No** ☐
5. Do you have a bone, muscle, or joint injury that bothers you? **Yes** ☐ **No** ☐

Medical Questions
1. Do you have any history of juvenile arthritis or connective tissue disease? **Yes** ☐ **No** ☐
2. Do any of your joints become painful, swollen, warm, or look red? **Yes** ☐ **No** ☐
3. Do you cough, wheeze, or have difficulty breathing during or after exercise? **Yes** ☐ **No** ☐
4. Have you ever used an inhaler or taken asthma medicine? **Yes** ☐ **No** ☐
5. Is there anyone in your family who has asthma? **Yes** ☐ **No** ☐
6. Were you born without or are you missing a kidney, eye, testicle (males), spleen, or any other organ? **Yes** ☐ **No** ☐
7. Do you have groin pain or a painful bulge or hernia in the groin area? **Yes** ☐ **No** ☐
8. Have you had infectious mononucleosis (mono) within the last month? **Yes** ☐ **No** ☐
9. Do you have any rashes, pressure sores, or other skin problems? **Yes** ☐ **No** ☐
10. Have you had a herpes or MRSA skin infection? **Yes** ☐ **No** ☐
11. Have you ever had a head injury or concussion? **Yes** ☐ **No** ☐
12. Do you have a history of seizure disorder? **Yes** ☐ **No** ☐
13. Do you have headaches with exercise? **Yes** ☐ **No** ☐
14. Have you ever become ill while exercising in the heat? **Yes** ☐ **No** ☐
15. Do you get frequent muscle cramps when exercising? **Yes** ☐ **No** ☐
16. Have you had any problems with your eyes or vision? **Yes** ☐ **No** ☐
17. Have you had any eye injuries? **Yes** ☐ **No** ☐
18. Do you wear glasses or contact lenses? **Yes** ☐ **No** ☐
19. Have you ever had hearing loss or problems with your hearing? **Yes** ☐ **No** ☐
20. Are you on a special diet or do you avoid certain types of foods? **Yes** ☐ **No** ☐
21. Have you ever had an eating disorder? **Yes** ☐ **No** ☐
22. Do you have any other medical problems? **Yes** ☐ **No** ☐

I have reviewed the History Form, and I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct.	
Signature:	**Date**:

Validate Email