The Commonwealth of Massachusetts
County of Plymouth
Sheriff's Office
Plymouth County Correctional Facility

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Joseph D. McDonald, Jr
Sheriff

Gerald C. Pudolsky
Special Sheriff

APPLICANT HEALTH HISTORY FORM

Name: _____

Address: _____

Date Of Birth: ____ / ____ / ____ Phone Number: _____

Position applied for: _____

☐ **I hereby attest that I have provided the corresponding job description to my medical examiner.**

PERSONAL HEALTH HISTORY

	Yes	No	If yes, give details
Are you currently being treated by any doctor for any illness?	☐	☐	
Are you currently taking any medications including inhalers?	☐	☐	
Are you allergic to anything?	☐	☐	
Have you had any broken bones or fractures?	☐	☐	
Do you suffer from back, neck or spinal problems including whiplash?	☐	☐	
Have you visited a chiropractor or physiotherapist in the last year?	☐	☐	
Have you ever had an X-ray or scan of your neck or back?	☐	☐	
Have you ever been treated for any cardiac conditions?	☐	☐	
Have you ever had trouble wearing any personal protective equipment?	☐	☐	
Do you currently smoke?	☐	☐	
Have you ever smoked?	☐	☐	
Have you been exposed to any toxic substances or environmental hazards?	☐	☐	
Do you suffer or have you ever suffered from occupational overuse syndrome (ex: tennis elbow or Tenosynovitis)?	☐	☐	

I hereby declare under the penalties of perjury, that the answers to the questions are true.

Signature: _____ Date: _____

RESULTS OF PHYSICAL MEDICAL EXAMINATION

Date: _____

Patient Name: _____

Height: _____ Ft. _____ Inches **Weight** _____ Lbs.

Temperature: ☐ Normal ☐ Abnormal **Pulse:** ☐ Normal ☐ Abnormal **Color Vision:** ☐ Normal ☐ Abnormal

TUNERCULOSIS TEST

Date of Tuberculosis Test: _____ **Date Test was read:** _____

Result of Tuberculosis Test: ☐ Positive ☐ Negative

AREA EXAMINED

Head and Neck	Y☐	Abdomen	Y☐	Musculo – Skeletal System	Y☐
Mouth and Throat	Y☐	Abdominal Wall	Y☐	Spine / Pelvis	Y☐
Nose and Sinuses	Y☐	Liver	Y☐	Upper Extremities	Y☐
Ears	Y☐	Spleen	Y☐	Lower Extremities	Y☐
Eyes (Incl. Funduscopic)	Y☐	Kidneys	Y☐	Other	Y☐
Lymph Nodes	Y☐	G.I. Tract	Y☐	Skin	Y☐
Thyroid Glandes	Y☐	Other	Y☐	Peripheral Vascular System	Y☐
Other	Y☐	Anal- Rectum	Y☐	Neurologic Examination	Y☐
Chest	Y☐	Inguinal- Femoral	Y☐	Emotional Status	Y☐
Chest Wall	Y☐	Lymph Nodes	Y☐	Other	Y☐
Breasts	Y☐	Genital	Y☐		
Lungs	Y☐				
Heart	Y☐				
Other	Y☐				

All areas examined are within normal limits ☐ Yes ☐ No

After reviewing the provided job description this individual can perform all the functions of the position: ☐ Yes ☐ No

ALL INFORMATION ON THIS FORM IS FOR CONFIDENTIAL USE ONLY

Physician's concise summary and/or remarks:

Physician's Printed Name: _____

Physician's Signature: _____ **Date:** _____

Physician's address: _____

Physician's contact number: _____