CONFIDENTIAL

# FITNESS-FOR-LIFE PROGRAM
# MEDICAL HISTORY QUESTIONNAIRE

**COUNTY OF LOS ANGELES**

At the time of your appointment for medical evaluation you must present this questionnaire, completed to the medical/nursing service. It is not to be given or shown to anyone else, in order to protect its confidentiality.

| NAME (LAST,FIRST, MIDDLE): | EMPLOYEE NUMBER | BIRTHDAY | AGE |
|---|---|---|---|
| ADDRESS: | CITY: | STATE, ZIP CODE | |
| PRESENT POSITION: | HOME PHONE NO. ( ) | WORK PHONE NO. ( ) | |

In order for you to gain the most benefit from the Wellness program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, it may be left blank. However, **if you are a certified HAZMAT technician or specialist, you must answer all questions preceded by an asterisk (*). Failure to answer these questions may result in restrictions against HAZMAT work**. Please explain all "Yes" and "Not Sure" answers on page 5.

**Have you have ever had any of the following conditions?**

| YES | NOT SURE | NO | |
|---|---|---|---|
| ____ | ____ | ____ | 1. Loss of Hearing |
| ____ | ____ | ____ | 2. *Asthma |
| ____ | ____ | ____ | 3. *Pneumonia |
| ____ | ____ | ____ | 4. *Pneumothorax |
| ____ | ____ | ____ | 5. *Blood Clot in Lungs |
| ____ | ____ | ____ | 6. *Kidney Disease |
| ____ | ____ | ____ | 7. Prostatitis |
| ____ | ____ | ____ | 8. Colitis |
| ____ | ____ | ____ | 9. *Hepatitis |
| ____ | ____ | ____ | 10. *Liver Disease |
| ____ | ____ | ____ | 11. *Elevated Liver Enzyme Test |
| ____ | ____ | ____ | 12. Pancreatitis |
| ____ | ____ | ____ | 13. Ulcer |
| ____ | ____ | ____ | 14. *Heart Attack |
| ____ | ____ | ____ | 15. Heart Murmur |
| ____ | ____ | ____ | 16. *Positive Stress Test |
| ____ | ____ | ____ | 17. Heart Valve Abnormality |

| YES | NOT SURE | NO | |
|---|---|---|---|
| ____ | ____ | ____ | 18. *Angina |
| ____ | ____ | ____ | 19. *Heart Failure |
| ____ | ____ | ____ | 20. High Cholesterol |
| ____ | ____ | ____ | 21. *High Blood Pressure |
| ____ | ____ | ____ | 22. Arthritis/Rheumatism |
| ____ | ____ | ____ | 23. Loss of Consciousness |
| ____ | ____ | ____ | 24. Epilepsy |
| ____ | ____ | ____ | 25. Convulsions/Seizures |
| ____ | ____ | ____ | 26. Stroke |
| ____ | ____ | ____ | 27. Diabetes |
| ____ | ____ | ____ | 28. Thyroid Trouble |
| ____ | ____ | ____ | 29. Anemia |
| ____ | ____ | ____ | 30. Eczema |
| ____ | ____ | ____ | 31. Cancer (including Skin) |
| ____ | ____ | ____ | 32. Sleep Apnea |
| ____ | ____ | ____ | 33. Chronic Muscular Disease |
| ____ | ____ | ____ | 34. Chronic Neurological Disease |

**Do you currently have or have you recently had any of the following? Please explain all "Yes" and "Not Sure" answers on page 5.**

| YES | NOT SURE | NO | |
|---|---|---|---|
| ____ | ____ | ____ | 35. Difficulty with Night Vision |
| ____ | ____ | ____ | 36. Change in Vision |
| ____ | ____ | ____ | 37. Blurred or Double Vision |
| ____ | ____ | ____ | 38. Bleeding Gums |
| ____ | ____ | ____ | 39. Frequent Nose Bleeds |
| ____ | ____ | ____ | 40. Frequent Sinus Trouble |
| ____ | ____ | ____ | 41. Recent Hoarseness |
| ____ | ____ | ____ | 42. Ringing/Buzzing Ears |
| ____ | ____ | ____ | 43. Ear Aches |
| ____ | ____ | ____ | 44. *Shortness of Breath |
| ____ | ____ | ____ | 45. *Chronic or Frequent Cough |
| ____ | ____ | ____ | 46. Brown or Blood-Tinged Sputum |
| ____ | ____ | ____ | 47. *Chest Tightness |
| ____ | ____ | ____ | 48. *Wheezing |
| ____ | ____ | ____ | 49. Bladder Trouble |
| ____ | ____ | ____ | 50. Blood in Urine |
| ____ | ____ | ____ | 51. Irregular Vaginal Bleeding |
| ____ | ____ | ____ | 52. *Currently Pregnant |
| ____ | ____ | ____ | 53. Difficulty Starting or Stopping Urination |
| ____ | ____ | ____ | 54. Urinating 3 Times Per Night |
| ____ | ____ | ____ | 55. Frequent or Painful Urination |
| ____ | ____ | ____ | 56. Problems with Sexual Function |
| ____ | ____ | ____ | 57. Infertility |
| ____ | ____ | ____ | 58. Vomited Blood |
| ____ | ____ | ____ | 59. Persistent Diarrhea |
| ____ | ____ | ____ | 60. Persistent Constipation |
| ____ | ____ | ____ | 61. Frequent Abdominal Pain |
| ____ | ____ | ____ | 62. Frequent Nausea |
| ____ | ____ | ____ | 63. Frequent Indigestion or Heartburn |
| ____ | ____ | ____ | 64. Black or Bloody Bowel Movement |
| ____ | ____ | ____ | 65. Hemorrhoids |

| YES | NOT SURE | NO | |
|---|---|---|---|
| ____ | ____ | ____ | 66. Trouble Swallowing |
| ____ | ____ | ____ | 67. Hernia |
| ____ | ____ | ____ | 68. Fainting Spells |
| ____ | ____ | ____ | 69. Recurrent Dizziness |
| ____ | ____ | ____ | 70. Frequent Headaches |
| ____ | ____ | ____ | 71. Tremors |
| ____ | ____ | ____ | 72. Memory Loss |
| ____ | ____ | ____ | 73. Loss of Coordination |
| ____ | ____ | ____ | 74. Numbness/Tingling of Extremities |
| ____ | ____ | ____ | 75. Recurrent Nightmares |
| ____ | ____ | ____ | 76 Intrusive Images |
| ____ | ____ | ____ | 77 Inability to Focus |
| ____ | ____ | ____ | 78 Difficulty Concentrating |
| ____ | ____ | ____ | 79 Anxiety |
| ____ | ____ | ____ | 80. Panic Attacks |
| ____ | ____ | ____ | 81. Depression |
| ____ | ____ | ____ | 82. Irregular Heartbeat |
| ____ | ____ | ____ | 83. Chest Pain |
| ____ | ____ | ____ | 84. Swelling of Feet |
| ____ | ____ | ____ | 85. Leg Pain While Walking |
| ____ | ____ | ____ | 86. Painful Varicose Veins |
| ____ | ____ | ____ | 87. Back Trouble/Pain |
| ____ | ____ | ____ | 88. Neck Trouble/Pain |
| ____ | ____ | ____ | 89. Joint Pain/Swelling |
| ____ | ____ | ____ | 90. Carpal Tunnel Syndrome |
| ____ | ____ | ____ | 91. Bleeding/Bruising Easily |
| ____ | ____ | ____ | 92. Enlarged Glands |
| ____ | ____ | ____ | 93. Rashes |
| ____ | ____ | ____ | 94. Unexplained Lumps |
| ____ | ____ | ____ | 95. Chronic Fatigue |
| ____ | ____ | ____ | 96. Night Sweats |
| ____ | ____ | ____ | 97. Undesired Weight Loss |
| ____ | ____ | ____ | 98. Snoring |
| ____ | ____ | ____ | 99. Difficulty sleeping |
| ____ | ____ | ____ | 100. Low Blood Sugar |

| YES | NOT SURE | NO | | Please explain all "Yes" and "Not Sure" answers on page 5. |
|---|---|---|---|---|
| ____ | ____ | ____ | 101. | Are you experiencing any stresses, mood problems, financial problems, relationships difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis? |
| ____ | ____ | ____ | 102. | Have you been absent from work due to stress in the past year? |
| ____ | ____ | ____ | 103. | *Have you taken any prescription medications during the last 6 months? List name, frequency of use, and the reason for the medication on page 5. |
| ____ | ____ | ____ | 104. | Have you had any surgical operations in the last 10 years? |
| ____ | ____ | ____ | 105. | *Do you currently have a cold/cough or have you had any in the last two weeks? |
| ____ | ____ | ____ | 106. | *Have you inhaled smoke in the last 24 hours? |
| ____ | ____ | ____ | 107. | Have you been hospitalized in the last 10 years? If "yes", list date, length of stay, and reason on page 5. |
| ____ | ____ | ____ | 108. | *Are you currently under a doctor's care? If yes, please describe what you are being treated for on page 5. |
| ____ | ____ | ____ | 109. | Have you ever been advised by a Wellness Program or County physician to see your private physician to follow-up on a problem? |
| ____ | ____ | ____ | 110. | Have you had a change in the size or color of a mole, or a sore that would not heal in the past year? |
| ____ | ____ | ____ | 111. | Have you been exposed to loud noise today? |
| ____ | ____ | ____ | 112. | *Do you have any physical activity limitations or difficulties performing work tasks? |
| ____ | ____ | ____ | 113. | Is there any medical reason for you to not complete your treadmill, strength, and/or flexibility measurements today? |
| ____ | ____ | ____ | 114. | *Are you a current cigarette smoker?<br>A. How many packs of cigarettes do you smoke a day? ______________________<br>B. How long have you been smoking? ______________________________________ |
| ____ | ____ | ____ | 115. | *Are you an ex-smoker?<br>A. How many years did you smoke? ____________<br>B. How many packs a day? __________________<br>C. When did you quit? _______________________ |
| ____ | ____ | ____ | 116. | Have you used chewing tobacco or smoked cigars or pipe in the last 15 years? |
| ____ | ____ | ____ | 117. | Has someone ever been concerned about you drinking/drug use or suggested you cut down? |
| ____ | ____ | ____ | 118. | Has someone ever been angry or upset about you drinking or drug use? |
| ____ | ____ | ____ | 119. | Have you been convicted for driving under the influence (DUI) in the last five years? |
| ____ | ____ | ____ | 120. | Have you ever felt bad about your drinking or drug use? |
| ____ | ____ | ____ | 121. | Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? |

122. *I drink ____ beers; _____ ounces of hard liquor; _____ ounces of wine per week.

123. When were your last immunizations?

Tetanus ________ Flu shot _______ Hepatitis B_________

124. When were your most recent health maintenance screening tests?

Cholesterol _______ Results? ___________________________

PSA (Prostate) _______ Results?___________________________

Sigmoidoscopy _______ Results?___________________________

Mammogram _______ Results? ___________________________

Pap Smear _______ Results? ___________________________

125 My last chest x-ray was in ________(year).

126. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dusty conditions:______________________________________________________________

127. Please describe your typical on-duty and off-duty exercise habits including cardiovascular, strength, and flexibility training:

| ACTIVITY | HOW MUCH TIME DO YOU SPEND DOING THIS ACTIVITY PER WEEK? | HAVE YOU BEEN DOING THIS ACTIVITY? HOW MANY MONTHS/YEARS |
|---|---|---|
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| | | |

128. My current diet could be best characterized as (check all that apply):

____ Low fat ___ Low carb ___ High protein ___ Vegetarian/Vegan ____No special diet

## SUPPLEMENTAL INFORMATION

When you have answered "Yes" or "Not Sure" to any question on this form, please provide details including dates of occurrence in the space below. Identify each explanation by the corresponding number.

| QUESTION NUMBER | |
|---|---|
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| | (If Needed, Please Attach An Additional Sheet) |

| TYPED OR PRINTED NAME : | COMPLETE SIGNATURE: | DATE: |
|---|---|---|
| | | |