

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		YES	NOT SURE	NO	
_____	_____	_____	1. Loss of Hearing	_____	_____	_____	18. *Angina
_____	_____	_____	2. *Asthma	_____	_____	_____	19. *Heart Failure
_____	_____	_____	3. *Pneumonia	_____	_____	_____	20. High Cholesterol
_____	_____	_____	4. *Pneumothorax	_____	_____	_____	21. *High Blood Pressure
_____	_____	_____	5. *Blood Clot in Lungs	_____	_____	_____	22. Arthritis/Rheumatism
_____	_____	_____	6. *Kidney Disease	_____	_____	_____	23. Loss of Consciousness
_____	_____	_____	7. Prostatitis	_____	_____	_____	24. Epilepsy
_____	_____	_____	8. Colitis	_____	_____	_____	25. Convulsions/Seizures
_____	_____	_____	9. *Hepatitis	_____	_____	_____	26. Stroke
_____	_____	_____	10. *Liver Disease	_____	_____	_____	27. Diabetes
_____	_____	_____	11. *Elevated Liver Enzyme Test	_____	_____	_____	28. Thyroid Trouble
_____	_____	_____	12. Pancreatitis	_____	_____	_____	29. Anemia
_____	_____	_____	13. Ulcer	_____	_____	_____	30. Eczema
_____	_____	_____	14. *Heart Attack	_____	_____	_____	31. Cancer (including Skin)
_____	_____	_____	15. Heart Murmur	_____	_____	_____	32. Sleep Apnea
_____	_____	_____	16. *Positive Stress Test	_____	_____	_____	33. Chronic Muscular Disease
_____	_____	_____	17. Heart Valve Abnormality	_____	_____	_____	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		YES	NOT SURE	NO	
_____	_____	_____	35. Difficulty with Night Vision	_____	_____	_____	66. Trouble Swallowing
_____	_____	_____	36. Change in Vision	_____	_____	_____	67. Hernia
_____	_____	_____	37. Blurred or Double Vision	_____	_____	_____	68. Fainting Spells
_____	_____	_____	38. Bleeding Gums	_____	_____	_____	69. Recurrent Dizziness
_____	_____	_____	39. Frequent Nose Bleeds	_____	_____	_____	70. Frequent Headaches
_____	_____	_____	40. Frequent Sinus Trouble	_____	_____	_____	71. Tremors
_____	_____	_____	41. Recent Hoarseness	_____	_____	_____	72. Memory Loss
_____	_____	_____	42. Ringing/Buzzing Ears	_____	_____	_____	73. Loss of Coordination
_____	_____	_____	43. Ear Aches	_____	_____	_____	74. Numbness/Tingling of Extremities
_____	_____	_____	44. *Shortness of Breath	_____	_____	_____	75. Recurrent Nightmares
_____	_____	_____	45. *Chronic or Frequent Cough	_____	_____	_____	76. Intrusive Images
_____	_____	_____	46. Brown or Blood-Tinged Sputum	_____	_____	_____	77. Inability to Focus
_____	_____	_____	47. *Chest Tightness	_____	_____	_____	78. Difficulty Concentrating
_____	_____	_____	48. *Wheezing	_____	_____	_____	79. Anxiety
_____	_____	_____	49. Bladder Trouble	_____	_____	_____	80. Panic Attacks
_____	_____	_____	50. Blood in Urine	_____	_____	_____	81. Depression
_____	_____	_____	51. Irregular Vaginal Bleeding	_____	_____	_____	82. Irregular Heartbeat
_____	_____	_____	52. *Currently Pregnant	_____	_____	_____	83. Chest Pain
_____	_____	_____	53. Difficulty Starting or Stopping Urination	_____	_____	_____	84. Swelling of Feet
_____	_____	_____	54. Urinating 3 Times Per Night	_____	_____	_____	85. Leg Pain While Walking
_____	_____	_____	55. Frequent or Painful Urination	_____	_____	_____	86. Painful Varicose Veins
_____	_____	_____	56. Problems with Sexual Function	_____	_____	_____	87. Back Trouble/Pain
_____	_____	_____	57. Infertility	_____	_____	_____	88. Neck Trouble/Pain
_____	_____	_____	58. Vomited Blood	_____	_____	_____	89. Joint Pain/Swelling
_____	_____	_____	59. Persistent Diarrhea	_____	_____	_____	90. Carpal Tunnel Syndrome
_____	_____	_____	60. Persistent Constipation	_____	_____	_____	91. Bleeding/Bruising Easily
_____	_____	_____	61. Frequent Abdominal Pain	_____	_____	_____	92. Enlarged Glands
_____	_____	_____	62. Frequent Nausea	_____	_____	_____	93. Rashes
_____	_____	_____	63. Frequent Indigestion or Heartburn	_____	_____	_____	94. Unexplained Lumps
_____	_____	_____	64. Black or Bloody Bowel Movement	_____	_____	_____	95. Chronic Fatigue
_____	_____	_____	65. Hemorrhoids	_____	_____	_____	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?
A. How many packs of cigarettes do you smoke a day? _____
B. How long have you been smoking? _____ |
| _____ | _____ | _____ | 115. *Are you an ex-smoker?
A. How many years did you smoke? _____
B. How many packs a day? _____
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	HAVE	HOW MUCH TIME DO YOU SPEND DOING THIS ACTIVITY PER WEEK?	HOW MANY MONTHS/YEARS YOU BEEN DOING THIS ACTIVITY?
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

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

____ Low fat ____ Low carb ____ High protein ____ Vegetarian/Vegan ____ No special diet

