CONFIDENTIAL

WELLNESS 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):	SOC SEC 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” answers on page 5.

Personal Medical History: Have you have ever had any of the following conditions?:

YES 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 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 Cancer)
___ ___ 32. Sleep Apnea
___ ___ 33. Chronic Muscular Disease
___ ___ 34. Chronic Neurological Disease

Review of Symptoms: Do you currently have or have you recently had any of the following?:
Please explain all "Yes" answers on page 5.

YES NO

EYES, EARS, NOSE, THROAT

___ ___ 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

PULMONARY

___ ___ 44. *Shortness of Breath
___ ___ 45. *Chronic or Frequent Cough
___ ___ 46. Brown or Blood-Tinged Sputum
___ ___ 47. *Chest Tightness
___ ___ 48. *Wheezing

GENITO-URINARY

___ ___ 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

GASTROINTESTINAL

___ ___ 58. Vomited Blood
___ ___ 59. Persistent Diarrhea
___ ___ 60. Persistent Constipation
___ ___ 61. Frequent Abdominal Pain
___ ___ 62. Frequent Nausea
___ ___ 63. Frequent Indigestion/Heartburn
___ ___ 64. Black or Bloody Bowel Movement
___ ___ 65. Hemorrhoids
___ ___ 66. Trouble Swallowing
___ ___ 67. Hernia

YES NO

CENTRAL NERVOUS SYSTEM

___ ___ 68. Fainting Spells
___ ___ 69. Recurrent Dizziness
___ ___ 70. Frequent Headaches
___ ___ 71. Tremors
___ ___ 72. Memory Loss
___ ___ 73. Loss of Coordination
___ ___ 74. Numbness/Tingling of Extremities

MENTAL HEALTH

___ ___ 75. Recurrent Nightmares
___ ___ 76 Intrusive Images
___ ___ 77 Inability to Focus
___ ___ 78 Difficulty Concentrating
___ ___ 79 Anxiety
___ ___ 80. Panic Attacks
___ ___ 81. Depression

HEART/VASCULAR

___ ___ 82. Palpitation (Irreg. Heartbeat)
___ ___ 83. Pain or Discomfort in Chest
___ ___ 84. Swelling of Feet
___ ___ 85. Leg Pain While Walking
___ ___ 86. Painful Varicose Veins

MUSCULO/SKELETAL.

___ ___ 87. Back Trouble/Pain
___ ___ 88. Neck Trouble/Pain
___ ___ 89. Joint Injury/Pain/Swelling
___ ___ 90. Carpal Tunnel Syndrome

MISCELLANEOUS

___ ___ 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 NO **Please explain all "Yes" answers on page 5.**

___ ___101. Are you experiencing any stresses, mood problems, financial problems, relationship 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. *Do you occasionally use or are you currently taking any prescription or over the counter medications? List name, dosage, frequency of use, and the reason the medication is used on page 5.

___ ___ 104. Have you had any surgical operations in the last 10 years?

___ ___ 105. Has anyone in your immediate family developed heart disease before the age of 60?

___ ___ 106. *Do you currently have a cold/cough or have you had any in the last two weeks?

___ ___ 107. *Have you inhaled smoke in the last 24 hours?

___ ___ 108. Have you been hospitalized in the last 10 years? If "yes", list date, length of stay, and reason on page 5.

___ ___ 109. *Are you currently under a doctor's care? If yes, please describe what you are being treated for on page 5.

___ ___ 110. Have you ever been advised by a Wellness Program or County physician to see your private physician to follow-up on a problem?

___ ___ 111. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?

___ ___ 112. Have you been exposed to loud noise today?

___ ___ 113. *Do you have any physical activity limitations or difficulties performing firefighting tasks?

___ ___ 114. Is there any medical reason for you to not complete your treadmill, strength, and/or flexibility measurements today?

___ ___ 115. *Are you a current cigarette smoker?
A. How many packs of cigarettes do you smoke a day? ______________________
B. How long have you been smoking? ____________________________________

___ ___ 116. *Are you an ex-smoker?
A. How many years did you smoke? ____________
B. How many packs a day? ____________________
C. When did you quit? ________________________

___ ___ 117. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

___ ___ 118. Has someone ever been concerned about you drinking/drug use or suggested you cut down?

___ ___ 119. Has someone ever been angry/upset about you drinking/drug use?

___ ___ 120. Have you been convicted for driving under the influence (DUI) in the last five years?

___ ___ 121. Have you ever felt bad about your drinking/drug use?

___ ___ 122. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

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

124. When were your last immunizations?

Tetanus ________ Flu shot _______ Hepatitis B_________

125. When were your most recent health maintenance screening tests?:

Cholesterol _______ Results? ___________________________

Hep B Titer _______ Results? ___________________________

Mammogram ______ Results? ___________________________

Pap Smear _______ Results? ___________________________

PSA (Prostate) _______ Results?___________________________

Sigmoidoscopy _______ Results?___________________________

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

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

128. 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?	HOW MANY MONTHS/YEARS HAVE YOU BEEN DOING THIS ACTIVITY?

129. 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” 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	
	(If Needed, Please Attach An Additional Sheet)