

CONFIDENTIAL

EXECUTIVE HEALTH MEDICAL HISTORY QUESTIONNAIRE

OCCUPATIONAL HEALTH PROGRAM CHIEF EXECUTIVE OFFICE 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	BIRTHDATE:	AGE:
ADDRESS:	CITY:	STATE, ZIP CODE	
PRESENT POSITION:	HOME TELEPHONE ()	WORK TELEPHONE ()	

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all "Yes" answers on page 4.

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

- | | | |
|---------|-------------------------------|--|
| YES NO | | YES NO |
| ___ ___ | 1. Allergies | ___ ___ 16. Angina |
| ___ ___ | 2. Loss of Hearing | ___ ___ 17. Heart Failure |
| ___ ___ | 3. Asthma | ___ ___ 18. High Cholesterol |
| ___ ___ | 4. Kidney Disease | ___ ___ 19. High Blood Pressure |
| ___ ___ | 5. Prostatitis | ___ ___ 20. Arthritis/Rheumatism |
| ___ ___ | 6. Colitis | ___ ___ 21. Loss of Consciousness |
| ___ ___ | 7. Hepatitis | ___ ___ 22. Epilepsy |
| ___ ___ | 8. Liver Disease | ___ ___ 23. Convulsions/Seizures |
| ___ ___ | 9. Elevated Liver Enzyme Test | ___ ___ 24. Stroke |
| ___ ___ | 10. Pancreatitis | ___ ___ 25. Diabetes |
| ___ ___ | 11. Ulcer | ___ ___ 26. Thyroid Trouble |
| ___ ___ | 12. Heart Attack | ___ ___ 27. Anemia |
| ___ ___ | 13. Heart Murmur | ___ ___ 28. Eczema |
| ___ ___ | 14. Positive Stress Test | ___ ___ 29. Cancer (including Skin Cancer) |
| ___ ___ | 15. Heart Valve Abnormality | ___ ___ 30. Sleep Apnea |

Review of Symptoms: Do you currently have or have you recently had any of the following? : Please explain all "Yes" answers on page 4.

YES NO

EYES, EARS, NOSE, THROAT

- ___ ___ 31. Difficulty with Night Vision
 ___ ___ 32. Change in Vision
 ___ ___ 33. Blurred or Double Vision
 ___ ___ 34. Bleeding Gums
 ___ ___ 35. Frequent Nose Bleeds
 ___ ___ 36. Frequent Sinus Trouble
 ___ ___ 37. Recent Hoarseness
 ___ ___ 38. Ringing/Buzzing Ears
 ___ ___ 39. Ear Aches

PULMONARY

- ___ ___ 40. Shortness of Breath
 ___ ___ 41. Chronic or Frequent Cough
 ___ ___ 42. Brown or Blood-Tinged Sputum
 ___ ___ 43. Chest Tightness
 ___ ___ 44. Wheezing

GENITO-URINARY

- ___ ___ 45. Bladder Trouble
 ___ ___ 46. Blood in Urine
 ___ ___ 47. Irregular Vaginal Bleeding
 ___ ___ 48. Currently Pregnant
 ___ ___ 49. Difficulty Starting or Stopping Urination
 ___ ___ 50. Urinating 3 Times Per Night
 ___ ___ 51. Frequent or Painful Urination
 ___ ___ 52. Problems with Sexual Function

GASTROINTESTINAL

- ___ ___ 53. Vomited Blood
 ___ ___ 54. Persistent Diarrhea
 ___ ___ 55. Persistent Constipation
 ___ ___ 56. Frequent Abdominal Pain
 ___ ___ 57. Frequent Nausea
 ___ ___ 58. Frequent Indigestion/Heartburn
 ___ ___ 59. Black or Bloody Bowel Movement
 ___ ___ 60. Hemorrhoids
 ___ ___ 61. Trouble Swallowing
 ___ ___ 62. Hernia

YES NO

CENTRAL NERVOUS SYSTEM

- ___ ___ 63. Fainting Spells
 ___ ___ 64. Recurrent Dizziness
 ___ ___ 65. Frequent Headaches
 ___ ___ 66. Tremors
 ___ ___ 67. Memory Loss
 ___ ___ 68. Loss of Coordination
 ___ ___ 69. Difficulty Concentrating
 ___ ___ 70. Numbness/Tingling of Extremities

HEART/VASCULAR

- ___ ___ 71. Palpitation (Irreg. Heartbeat)
 ___ ___ 72. Pain or Discomfort in Chest
 ___ ___ 73. High Cholesterol
 ___ ___ 74. Swelling of Feet
 ___ ___ 75. Leg Pain While Walking
 ___ ___ 76. Painful Varicose Veins

MUSCULO/SKELETAL.

- ___ ___ 77. Back Trouble/Pain
 ___ ___ 78. Neck Trouble/Pain
 ___ ___ 79. Joint Injury/Pain/Swelling
 ___ ___ 80. Carpal Tunnel Syndrome

MISCELLANEOUS

- ___ ___ 81. Bleeding/Bruising Easily
 ___ ___ 82. Enlarged Glands
 ___ ___ 83. Rashes
 ___ ___ 84. Unexplained Lumps
 ___ ___ 85. Chronic Fatigue
 ___ ___ 86. Night Sweats
 ___ ___ 87. Undesired Weight Loss
 ___ ___ 88. Snoring
 ___ ___ 89. Difficulty sleeping
 ___ ___ 90. Low Blood Sugar

YES NO

Please explain all "Yes" answers on page 4.

- ___ ___ 91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
- ___ ___ 92. Do you occasionally use or are you currently taking any prescription or over the counter medications? List name, dosage, and the reason the medication is used on page 4.
- ___ ___ 93. Have you had any surgical operations in the last 10 years?
- ___ ___ 94. Has anyone in your immediate family developed heart disease before the age of 60?
- ___ ___ 95. Do any diseases run in your family?
- ___ ___ 96. Do you currently have a cold/cough or have you had any in the last two weeks?
- ___ ___ 97. Have you ever been hospitalized? If "yes", list date, length of stay, and reason on pg 4.
- ___ ___ 98. Are you currently under a doctor's care? If yes, please describe what you are being treated for on page 4.
- ___ ___ 99. Have you ever been advised by an Executive Medical Program or County physician to see your private physician to follow-up on a problem?
- ___ ___ 100. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
- ___ ___ 101. Do you have any special concerns regarding your health that you would like to discuss with the doctor today?
- ___ ___ 102. Are you a current cigarette smoker?
 A. How many packs of cigarettes do you smoke a day? _____
 B. How long have you been smoking? _____
- ___ ___ 103. Are you an ex-smoker?
 A. How many years did you smoke? _____
 B. How many packs a day? _____
 C. When did you quit? _____
- ___ ___ 104. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?
105. I drink ___ beers; ___ ounces of hard liquor; ___ ounces of wine per week.
106. When were your most recent immunizations?:
 Tetanus _____ Flu shot _____ Pneumovax _____
107. When were you most recent health maintenance screening tests?:
 Cholesterol _____ Results? _____ PSA (Prostate) _____ Results? _____
 Mammogram _____ Results? _____ Sigmoidoscopy _____ Results? _____
 Pap Smear _____ Results? _____
108. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust: _____
109. Please describe typical weekly exercise or physical activities including any exercise at work:

110. My current diet could be best characterized as (check all that apply):
 ___ Low fat ___ Low carb ___ High protein ___ Vegetarian/Vegan ___ No special diet

