CONFIDENTIAL

S.C.U.B.A. QUESTIONNAIRE

OCCUPATIONAL HEALTH PROGRAMS - COUNTY OF LOS ANGELES

At the time of your appointment 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 OR CELL NUMBER ( )	WORK NUMBER ( )	

An answer is required for each question. Explain all "Yes" and "Not Sure" answers on Page 3.

Have you had any of the following conditions in the last 10 years?

YES	NOT SURE	NO		YES	NOT SURE	NO	
___	___	___	1. Ear infections	___	___	___	25. Heart Valve Abnormality
___	___	___	2. Surfers Ear	___	___	___	26. Enlarged Heart
___	___	___	3. Sinus Trouble	___	___	___	27. Heart Failure
___	___	___	4. Perforated Eardrum	___	___	___	28. Positive Stress Test
___	___	___	5. Ear Surgery	___	___	___	29. Pacemaker
___	___	___	6. Hearing Trouble	___	___	___	30. Cardiac Stent or Surgery
___	___	___	7. Abnormal Hearing Test	___	___	___	31. High Blood Pressure
___	___	___	8. Face Fractures	___	___	___	32. Mental Hospitalization
___	___	___	9. Radiation Therapy to Head/Neck	___	___	___	33. Panic Attacks
___	___	___	10. Ruptured Ear Drum	___	___	___	34. Referred for Psychological Help
___	___	___	11. Ear Aches	___	___	___	35. Drug or Alcohol Treatment
___	___	___	12. Meniere's Disease	___	___	___	36. Kidney Disease
___	___	___	13. Mastoiditis	___	___	___	37. Bleeding Disorder
___	___	___	14. Asthma	___	___	___	38. Leukemia
___	___	___	15. Use of Albuterol	___	___	___	39. Sickle Cell Disease
___	___	___	16. Chest Tightness	___	___	___	40. Epilepsy
___	___	___	17. Wheezing	___	___	___	41. Convulsion or Seizure
___	___	___	18. Pneumothorax (Collapsed Lung)	___	___	___	42. Loss of Consciousness
___	___	___	19. Lung Cysts or Blebs	___	___	___	43. Stroke
___	___	___	20. Aseptic Necrosis	___	___	___	44. Transient Ischemic Attack (TIA)
___	___	___	21 Recurrent Bowel Obstruction	___	___	___	45. Chronic Neurological Disease
___	___	___	22. Hernia	___	___	___	46. Intracranial Aneurysm
___	___	___	23. Heart Attack	___	___	___	47. Vascular Malformation
___	___	___	24. Heart Murmur	___	___	___	48. Brain Tumor
				___	___	___	49. Diabetes

Have you had any of the following in the past year?

YES	NOT SURE	NO		YES	NOT SURE	NO	
___	___	___	50. Trouble clearing ears	___	___	___	60. Recurrent Vomiting
___	___	___	51. Blocked Eustachian Tube	___	___	___	61. Recurrent Heartburn
___	___	___	52. Sinus Trouble	___	___	___	62. Palpitation (Irreg. Heartbeat)
___	___	___	53. Hearing Trouble	___	___	___	63. Enlarged Heart
___	___	___	54. Abnormal Hearing Test	___	___	___	64. Pain or Discomfort in Chest
___	___	___	55. Dentures	___	___	___	65. Fainting Spell
___	___	___	56. Facial Paralysis	___	___	___	66. Recurrent Dizziness
___	___	___	57. Shortness of Breath	___	___	___	67. Migraine Headaches
___	___	___	58. Chronic or Frequent Cough	___	___	___	68. Low Blood Sugar
___	___	___	59. Trouble Swallowing				

YES	NOT SURE	NO	
___	___	___	69. 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 3.
___	___	___	70. Do you currently have a cold/cough or have you had any in the last two weeks?
___	___	___	71. Do you ever have any trouble equalizing the pressure in your ears?
___	___	___	72. Do you have any physical activity limitations?
___	___	___	73. Are you a current cigarette smoker? A. How many packs of cigarettes do you smoke a day? _____ B. How long have you been smoking? _____
___	___	___	74. Are you an ex-smoker? A. How many years did you smoke? _____ B. How many packs a day? _____ C. When did you quit? _____
___	___	___	75. Has someone ever been concerned about your drinking or suggested you cut down?
___	___	___	76. Have you been convicted for driving under the influence (DUI) in the last five years?
___	___	___	77. Have you ever felt bad about your drinking/drug use?
___	___	___	78. Have you ever had a drink first thing in the morning to get rid of a hangover?

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

80. Please describe your diving experience including details regarding frequency of diving, depths, and any episodes of air embolism, decompression sickness or other problems encountered during dives:

_____

_____

_____

81. Please describe your typical exercise or physical activity including any physical activity at work:

ACTIVITY:	HOW MANY HOURS DO YOU SPEND DOING THIS PER WEEK?	HOW LONG HAVE YOU BEEN DOING THIS ACTIVITY?	
#1 _____	_____	_____Months	_____Years
#2 _____	_____	_____Months	_____Years
#3 _____	_____	_____Months	_____Year

82. Do you get any symptoms with these activities such as chest, arm, or neck pain, chest tightness, palpitations lightheadedness, or irregular heart rate?

___No ___Yes (Please explain below)

SUPPLEMENTAL INFORMATION

When you have answered "Yes" or "Not Sure" to any question, write the details in the space below. Identify each explanation by the corresponding number. Explain in detail including the date of occurrence.

QUESTION #	
	(If Needed, Please Attach An Additional Sheet)

I hereby authorize the performance of a complete medical examination, x-rays, blood testing, and urine testing. I declare that my answers to the questions contained in this questionnaire are true to the best of my knowledge and belief. I am aware that urine and blood testing may be used to detect therapeutic medications to verify my answers. I am aware that any willful inaccuracy may result in disciplinary action.

TYPED OR PRINTED NAME:	COMPLETE SIGNATURE:	DATE: