

YES	NOT SURE	NO	<u>MUSCULO/SKELETAL</u>	YES	NOT SURE	NO	<u>MISCELLANEOUS</u>
___	___	___	53. Fractures or Broken Bones	___	___	___	86. Kidney Disease
___	___	___	54. Back Trouble, Pain, or Injury	___	___	___	87. Bladder Trouble
___	___	___	55. Scoliosis	___	___	___	88. Blood in Urine
___	___	___	56. Neck Trouble, Pain, or Injury	___	___	___	89. Prostatitis
___	___	___	57. Numbness of Extremities	___	___	___	90. Irregular Vaginal Bleeding
___	___	___	58. Arthritis or Rheumatism	___	___	___	91. Currently Pregnant
___	___	___	59. Joint Pain or Swelling	___	___	___	92. Menstrual Problem That Kept You From Work
___	___	___	60. Shoulder Dislocation, Pain, or Injury	___	___	___	93. Referred for Psychological Help
___	___	___	61. Elbow Trouble, Pain, or Injury	___	___	___	94. Drug or Alcohol Treatment
___	___	___	62. Wrist Trouble, Pain, or Injury	___	___	___	95. Mental Hospitalization
___	___	___	63. Hand Trouble, Pain, or Injury	___	___	___	96. Panic Attack
___	___	___	64. Hip Trouble, Pain, or Injury	___	___	___	97. Diabetes
___	___	___	65. Knee Trouble, Pain, or Injury	___	___	___	98. Thyroid Trouble
___	___	___	66. Shin Pain	___	___	___	99. Bleeding Tendencies
___	___	___	67. Leg Trouble, Pain, or Injury	___	___	___	100. Anemia
___	___	___	68. Ankle Trouble, Pain, or Injury	___	___	___	101. Enlarged Glands
___	___	___	69. Foot Trouble, Pain, or Injury	___	___	___	102. Skin Problems, Cancer, or Rashes
___	___	___	70. Carpal Tunnel Syndrome	___	___	___	103. Sun or Heat Intolerance
___	___	___	<u>CENTRAL NERVOUS SYSTEM</u>	___	___	___	104. Eczema
___	___	___	71. Epilepsy	___	___	___	105. Razor Bumps (Pseudofolliculitis Barbae)
___	___	___	72. Convulsion or Seizure	___	___	___	106. Cyst or Tumor
___	___	___	73. Fainting Spell	___	___	___	107. Cancer or Leukemia
___	___	___	74. Loss of Consciousness	___	___	___	108. Chronic Fatigue
___	___	___	75. Recurrent Dizziness	___	___	___	109. Night Sweats
___	___	___	76. Traumatic Brain Injury	___	___	___	110. Undesired Weight Loss
___	___	___	77. Migraine Headache	___	___	___	111. Claustrophobia
___	___	___	78. Frequent Headaches	___	___	___	112. Multiple Chemical Sensitivity
___	___	___	79. Stroke	___	___	___	113. Wool Allergy
___	___	___	80. Transient Ischemic Attack (TIA)	___	___	___	114. Sleep Apnea
___	___	___	81. Tremors	___	___	___	115. Snoring
___	___	___	82. Chronic Muscular Disease	___	___	___	116. Trouble Sleeping
___	___	___	83. Chronic Neurological Disease	___	___	___	117. Low Blood Sugar
___	___	___	84. Attention Deficit Disorder	___	___	___	118. Blood Clot in Lungs or Legs
___	___	___	85. Skull Bone Defect	___	___	___	

YES	NOT SURE	NO	
___	___	___	119. Do you have any physical activity limitations?
___	___	___	120. Do you need any special accommodations to assist you in performing required job tasks?
___	___	___	121. Do you ever get wheezing with exercise?
___	___	___	122. Have you ever taken medication to prevent wheezing or shortness of breath with exercise?
___	___	___	123. Have you ever worked for the County of Los Angeles before? If "yes", at what position, and in which department?
___	___	___	124. Have you ever been refused employment (including L.A. County positions) because of any physical, psychological, or medically related reason?
___	___	___	125. Have you ever been rejected for or discharged from a military position because of physical, psychological, or medically related reasons?
___	___	___	126. Have you ever failed a pre-placement medical or psychological examination?
___	___	___	127. Have you ever been terminated or resigned from employment, or had to change job positions due to a physical, psychological, or medically related reason?
___	___	___	128. Have you ever failed to complete a training academy due to a physical, psychological, or medically related reason?

YES NOT SURE NO

- 129. Have you ever had a positive drug or alcohol test?
130. Do you occasionally use or are you currently taking any prescription or over the counter medications?
131. Have you ever been absent from work due to job stress?
132. Have you ever had any surgical or arthroscopic procedures?
133. Do you currently have a cold or cough or have you had any in the last two weeks?
134. Have you ever been hospitalized for reasons other than pregnancy?
135. Are you currently under a health care provider's care for any medical condition?
136. Have you ever seen a health care provider for neck pain, injury, or problems?
137. Have you ever been off work because of neck pain, injury, or problems?
138. Have you ever seen a health care provider for back pain, injury, or problems?
139. Have you ever been off work because of back pain, injury, or problems?
140. Have you had a recent change in the size or color of a mole, or a sore that would not heal?
141. Have you ever had any problems using a gas mask?
142. Have you missed more than five days from work due to medical reasons in the past year?
143. Has your driver's license ever been suspended or revoked due to medical reasons?
144. Have you been exposed to loud noise today?
145. Are you a current cigarette smoker?
146. Are you an ex-smoker?
147. Have you used chewing tobacco or smoked cigars or a pipe in the last 15 years?
148. Has someone ever been concerned about your drinking or suggested that you cut down?
149. Have you ever been convicted of driving under the influence (DUI)?
150. Have you ever felt bad about your drinking?
151. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener)?

152. I am left right handed.

153. Per week, I usually drink beers, glasses or shots of hard liquor, and glasses of wine.

154. Describe any hobbies, recreation, or work activities that have exposed you to noise, chemicals, or dusty conditions:

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

Table with 3 columns: ACTIVITY:, HOW MANY HOURS DO YOU SPEND DOING THIS PER WEEK?, HOW LONG HAVE YOU BEEN DOING THIS ACTIVITY? (Months, Years). Rows #1, #2, #3.

156. Please describe your current job and all previous jobs held in the last 5 years (including military service):

Table with 4 columns: JOB TITLE:, PRIMARY DUTIES:, EMPLOYER:, APPROX DATES OF EMPLOYMENT: (TO, TO, TO, TO, TO).

EXAMINING DOCTOR'S HISTORY AND COMMENTS

(Please list Question # and Problem Name prior to each entry)

Did you document "last pill, last pain, last PCP" for all of the above conditions?

Doctor's Signature:

Doctor's Printed Name:

Date: