

CONFIDENTIAL

CLANDESTINE LAB MEDICAL HISTORY QUESTIONNAIRE

OCCUPATIONAL HEALTH PROGRAMS 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 AND DEPARTMENT:	TELEPHONE NO. ()	WORK TELEPHONE NO. ()	

Have you have ever had any of the following conditions?

YES	NOT SURE	NO		YES	NOT SURE	NO	
___	___	___	1. Asthma	___	___	___	6. Hepatitis
___	___	___	2. Pneumonia	___	___	___	7. Liver Disease
___	___	___	3. Pneumothorax	___	___	___	9. Pancreatitis
___	___	___	4. Blood Clot in Lungs	___	___	___	8. Elevated Liver Enzyme Test
___	___	___	5. Kidney Disease				

Do you currently have or have you recently had any of the following?

YES	NOT SURE	NO		YES	NOT SURE	NO	
___	___	___	10. Frequent Nose Bleeds	___	___	___	20. Tremors
___	___	___	11. Frequent Sinus Trouble	___	___	___	21. Memory Loss
___	___	___	12. Recent Hoarseness	___	___	___	22. Loss of Coordination
___	___	___	13. Shortness of Breath	___	___	___	23. Chest Tightness
___	___	___	14. Chronic or Frequent Cough	___	___	___	24. Wheezing
___	___	___	15. Brown or Blood-Tinged Sputum	___	___	___	25. Currently Pregnant
___	___	___	16. Trouble Swallowing	___	___	___	26. Infertility
___	___	___	17. Recurrent Dizziness	___	___	___	27. Chest Pain
___	___	___	18. Frequent Headaches	___	___	___	28. Enlarged Glands
___	___	___	19. Numbness/Tingling of Extremities	___	___	___	29. Rashes

