FITNESS-FOR-LIFE 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 should not to be given or shown to anyone else to protect confidentiality.

NAME (LAST,FIRST, MIDDLE):	LAST 4 SSN	BIRTHDAY	AGE
ADDRESS:	CITY:	STATE, ZIP CODE	
PRESENT POSITION:	CELL ( )	WORK PHONE ( )	

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. Please explain all "Yes" and "Not Sure" answers on page 5.

Have you <u>ever</u> had any of the following conditions?

YES	NOT SURE	NO		YES	NOT SURE	NO	
____	____	____	1. Loss of Hearing	____	____	____	18. Angina
____	____	____	2. Asthma	____	____	____	19. Heart Failure
____	____	____	3. Pneumonia	____	____	____	20. Thickened Heart Muscle
____	____	____	4. Pneumothorax	____	____	____	21. Atrial Fibrillation
____	____	____	5. Blood Clot in Lungs	____	____	____	22. Myocarditis (Heart Infection)
____	____	____	6. Kidney Disease	____	____	____	23. High Cholesterol
____	____	____	7. Prostatitis	____	____	____	24. High Blood Pressure
____	____	____	8. Colitis	____	____	____	25. Stroke
____	____	____	9. Hepatitis	____	____	____	26. Epilepsy
____	____	____	10. Liver Disease	____	____	____	27. Diabetes
____	____	____	11. Elevated Liver Enzymes	____	____	____	28. Thyroid Trouble
____	____	____	12. Pancreatitis	____	____	____	29. Anemia
____	____	____	13. Ulcer	____	____	____	30. Arthritis/Rheumatism
____	____	____	14. Heart Attack	____	____	____	31. Cancer (including Skin)
____	____	____	15. Heart Murmur	____	____	____	32. Sleep Apnea
____	____	____	16. Positive Stress Test	____	____	____	33. Chronic Muscular Disease
____	____	____	17. Heart Valve Abnormality	____	____	____	34. Chronic Neurological Disease

Please explain all "Yes" and "Not Sure" answers on page 5.

Do you currently have or have had in the last year any of the following? Please explain all ”Yes” and “Not Sure” answers on page 5.

YES	NOT SURE	NO		YES	NOT SURE	NO	
____	____	____	35. Difficulty with Night Vision	____	____	____	63. Black or Bloody Bowel Movement
____	____	____	36. Change in Vision				
____	____	____	37. Blurred or Double Vision	____	____	____	64. Hemorrhoids
____	____	____	38. Bleeding Gums	____	____	____	65. Trouble Swallowing
____	____	____	39. Frequent Nose Bleeds	____	____	____	66. Hernia
____	____	____	40. Frequent Sinus Trouble	____	____	____	67. Loss of Consciousness
____	____	____	41. Recent Hoarseness	____	____	____	68. Recurrent Dizziness
____	____	____	42. Ringing/Buzzing Ears	____	____	____	69. Frequent Headaches
____	____	____	43. Ear Aches	____	____	____	70. Tremors
____	____	____	44. Shortness of Breath	____	____	____	71. Memory Loss
____	____	____	45. Chronic or Frequent Cough	____	____	____	72. Loss of Coordination
____	____	____	46. Brown or Blood-Tinged Sputum	____	____	____	73. Numbness/Tingling of Extremities
____	____	____	47. Wheezing	____	____	____	74 Anxiety
____	____	____	48. Bladder Trouble	____	____	____	75. Depression
____	____	____	49. Blood in Urine	____	____	____	76. Irregular Heartbeat
____	____	____	50. Irregular Vaginal Bleeding	____	____	____	77. Chest Pain or Tightness
____	____	____	51. Pregnancy	____	____	____	78. Swelling of Feet
____	____	____	52. Difficulty Starting or Stopping Urination	____	____	____	79. Leg Pain While Walking
____	____	____	53. Urinating 3 Times Per Night	____	____	____	80. Painful Varicose Veins
____	____	____	54. Frequent or Painful Urination	____	____	____	81. Joint Pain/Swelling
____	____	____	55. Problems with Sexual Function	____	____	____	82. Undesired Weight Loss
____	____	____	56. Infertility	____	____	____	83. Undesired Weight Gain
____	____	____	57. Vomited Blood	____	____	____	84. Bleeding/Bruising Easily
____	____	____	58. Persistent Diarrhea	____	____	____	85. Enlarged Glands
____	____	____	59. Persistent Constipation	____	____	____	86. Rashes
____	____	____	60. Frequent Abdominal Pain	____	____	____	87. Unexplained Lumps
____	____	____	61. Frequent Nausea	____	____	____	88. Chronic Fatigue
____	____	____	62. Frequent Indigestion or Heartburn	____	____	____	89. Night Sweats
				____	____	____	90. Snoring
				____	____	____	91. Difficulty sleeping
				____	____	____	92. Low Blood Sugar

Please explain all ”Yes” and “Not Sure” answers on page 5.

YES	NOT SURE	NO		**Please explain all "Yes" and "Not Sure" answers on page 5.**
____	____	____	93.	Are you experiencing any stresses, mood problems, financial problems, relationships difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
____	____	____	94.	Have you been absent from work due to stress in the past year?
____	____	____	95.	Have you had any surgical operations in the last 5 years?
____	____	____	96.	Do you currently have a cold/cough or have you had any in the last two weeks?
____	____	____	97.	Have you inhaled smoke in the last 24 hours?
____	____	____	98.	Have you been hospitalized in the last 5 years? If "yes", list date, length of stay, and reason on page 5.
____	____	____	99.	Are you currently under a doctor's care? If yes, please describe what you are being treated for on page 5.
____	____	____	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.	Have you been exposed to loud noise today?
____	____	____	102.	Is there any medical reason for you to not complete your treadmill, strength, or flexibility measurements today?
____	____	____	103.	Are you a current cigarette smoker? A. How many packs of cigarettes do you smoke a day? _____ B. How long have you been smoking? _____
____	____	____	104.	Are you an ex-smoker? A. How many years did you smoke? _____ B. How many packs a day? _____ C. When did you quit? _____
____	____	____	105.	Have you used chewing tobacco or smoked cigars or pipe in the last 15 years?
____	____	____	106.	Has someone ever been concerned about your drinking or suggested you cut down?
____	____	____	107.	Has someone ever been angry or upset about you drinking?
____	____	____	108.	Have you been convicted for driving under the influence (DUI) in the last five years?
____	____	____	109.	Have you ever felt bad about your drinking?
____	____	____	110.	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Please explain all "Yes" and "Not Sure" answers on page 5.

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

112. Men age 50 or more: Date of last colonoscopy _____ Findings _____

113. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

_____

114. Have you taken any prescription medications during the last 6 months? Please give details below.

NAME	TAKEN HOW OFTEN?	REASON FOR MEDICATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

115. Please describe your typical on-duty and off-duty exercise including any flexibility training:

ACTIVITY:	HOURS PER WEEK?	HOW LONG HAVE YOU BEEN DOING THIS ACTIVITY?	
_____	_____	_____Months	_____Years
_____	_____	_____Months	_____Years
_____	_____	_____Months	_____Years
_____	_____	_____Months	_____Years

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

___No ___Yes (Please explain on Page 5)

117. Are you on any special diet?

___No ___Yes (Please explain):_____

SUPPLEMENTAL INFORMATION

When you have answered “Yes” or “Not Sure” 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)