CONFIDENTIAL

BASIC PRE-PLACEMENT
MEDICAL HISTORY QUESTIONNAIRE

OCCUPATIONAL HEALTH PROGRAMS
COUNTY OF LOS ANGELES

Please complete this questionnaire in PEN and present to the staff at the examination clinic. To protect your confidentiality, it should not be given or shown to anyone else. On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

NAME (LAST,FIRST MIDDLE):	SOC SECURITY NUMBER:	BIRTHDATE:	AGE:
ADDRESS:	CITY	STATE, ZIP CODE	
FOR WHICH COUNTY POSITION AND DEPARTMENT ARE YOU BEING MEDICALLY EXAMINED?		WORK PHONE ( )	
IF YOU PREVIOUSLY HAVE HAD AN EXAM FOR A COUNTY OF L.A. POSITION, PLEASE PROVIDE POSTION: DEPT: DATE:		HOME/CELL PHONE ( )	

A response is required for each item below. Do not leave any blanks. Check "Yes" if you have had any of the following conditions in the last two (2) years. Be sure to include conditions that were treated through the County of LA workers' compensation system. You must explain all "Yes" and "Not Sure" answers on Page 2.

YES	NOT SURE	NO		YES	NOT SURE	NO	
___	___	___	1. Worn Glasses or Contacts	___	___	___	27. Knee Trouble, Pain,or Injury
___	___	___	2. Cataract	___	___	___	28. Ankle Pain or Injury
___	___	___	3. Blurred or Double Vision	___	___	___	29. Foot Pain or Injury
___	___	___	4. Blind Spot	___	___	___	30. Carpal Tunnel Syndrome
___	___	___	5. Impaired Peripheral Vision	___	___	___	31. Referred for Psychological Help
___	___	___	6. Hearing Trouble				
___	___	___	7. Chronic or Frequent Cough	___	___	___	32. Mental Hospitalization
___	___	___	8. Kidney Disease	___	___	___	33. Drug or Alcohol Treatment
___	___	___	9. Menstrual Problem That Kept You From Work	___	___	___	34. Epilepsy
				___	___	___	35. Convulsion or Seizure
___	___	___	10. Heart Attack	___	___	___	36. Fainting Spell or Blackout
___	___	___	11. Irregular Heartbeat	___	___	___	37. Recurrent Dizziness
___	___	___	12. Chest Pain or Discomfort	___	___	___	38. Loss of Consciousness
___	___	___	13. Swelling of Feet or Legs	___	___	___	39. Migraine Headache
___	___	___	14. Leg Pain While Walking	___	___	___	40. Frequent Headaches
___	___	___	15. Painful Varicose Veins	___	___	___	41. Stroke
___	___	___	16. High Blood Pressure	___	___	___	42. Diabetes
___	___	___	17. Back Trouble, Pain, or Injury	___	___	___	43. Cancer or Leukemia
___	___	___	18. Neck Trouble, Pain, or Injury	___	___	___	44. Chronic Fatigue
___	___	___	19. Numbness of Extremities	___	___	___	45. Night Sweats
___	___	___	20. Arthritis or Rheumatism	___	___	___	46. Undesired Weight Loss
___	___	___	21. Joint Pain or Swelling	___	___	___	47. Chemical Sensitivity
___	___	___	22. Shoulder Pain or Injury	___	___	___	48. Traumatic Brain Injury
___	___	___	23. Elbow Trouble, Pain, or Injury	___	___	___	49. Chronic Neurological Disease
___	___	___	24. Wrist Trouble, Pain, or Injury				
___	___	___	25. Hand Trouble, Pain, or Injury	___	___	___	50. Other Condition That May Affect Job Performance
___	___	___	26. Hip Trouble, Pain, or Injury				

YES	NOT SURE	NO	
___	___	___	51. Do you have any physical activity limitations?
___	___	___	52. Do you need any special accommodations to assist you in performing any job tasks?
___	___	___	53. Have you worked for the County of Los Angeles before? If "yes", at what position, and in which department? _____
___	___	___	54. Have you been unable to keep a job or refused employment due to any physical, psychological, or other medically related reason in the last two years?
___	___	___	55. Do you occasionally or currently take any prescription or over the counter medications? List name, dosage, frequency of use, and the reason the medication below.
___	___	___	56. Has your driver's license been suspended or revoked due to medical reasons in the last two years?
___	___	___	57. Have you been absent from work due to job stress in the last two years?
___	___	___	58. Are you pregnant? If yes, what is your due date? _____
___	___	___	59. Have you ever had a positive skin test for tuberculosis?
___	___	___	60. Do you get short of breath when walking with other people of your own age on level ground?
___	___	___	61. Have you missed more than five days from work due to medical reasons in the past year?
___	___	___	62. Has someone expressed concern about your drinking in the last two years?
___	___	___	63. Have you been convicted of driving under the influence in the last two years?
___	___	___	64. Have you felt bad about your drinking in the last two years?
___	___	___	65. Have you had a drink in the morning to get rid of a hangover in the last two years?

66. Please describe your current job and all jobs held in the last 2 years (including military service):

JOB TITLE:	PRIMARY DUTIES:	EMPLOYER:	APPROXIMATE DATES OF EMPLOYMENT:
_____	_____	_____	_____ TO _____
_____	_____	_____	_____ TO _____
_____	_____	_____	_____ TO _____

SUPPLEMENTAL INFORMATION

If you have answered "Yes" or "Not Sure" to any questions, please provide detailed information below.

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

I hereby authorize the performance of a complete medical examination. I declare that my answers to the questions contained in this medical questionnaire are true to the best of my knowledge and belief. I am aware that any willful inaccuracy may be regarded as cause for dismissal or disqualification for employment.

Typed or Printed Name of Applicant (or Guardian if under 18):	Complete Signature:	Date:

EXAMINING DOCTOR'S HISTORY AND COMMENTS

(Please list Question # and Problem Name prior to each entry)		
Reminders:		
Did you document “last pill, last pain, last HCP” for all of the above conditions?		
If only +responses are to #1 or #53, then ask about last HCP visit and Rx (Prescription and OTC)		
Doctor's Signature:	Doctor's Printed Name:	Date: