COUNTY OF LOS ANGELES
Department of Human Resources
Occupational Health Programs
Phone: 213-433-7201 | Email: ohp@hr.lacounty.gov

CONFIDENTIAL
PRE-EMPLOYMENT/POST-OFFER (PEPO)
HEALTH HISTORY QUESTIONNAIRE

APPLICANT INSTRUCTIONS

1. Complete the Health History Questionnaire by entering/verifying your personal information below. This questionnaire may be completed electronically, but must be printed and taken with you on the day of your appointment.

2. The information you provide in this questionnaire is extremely important. It will be used by a physician to advise the County of your ability to perform the essential functions of the job safely, with or without restrictions. Please fill out the questionnaire completely and accurately. Do not leave any answers blank; use "N/A" if not applicable, or enter "Don't know."

3. On Page 5, complete the Applicant Information section only.

APPLICANT INFORMATION

Full Name *(last, first, middle)*				**Last 4 of SSN**	
Gender		**Date of Birth**		**Age**	
Classification Title				**Item Number**	
Department					
Home Address					
City			**State**	**Zip Code**	
Personal Telephone Number					
Personal Email Address					

HEALTH SURVEY

Please answer all of the questions as accurately as possible, and do not leave any questions blank.

1. Are you presently taking any medications (prescription or non-prescription) that affects your balance, awareness, hearing, sight, or ability to walk, stand, sit, lift, bend, or reach? ☐ **Yes** ☐ **No**

   If your answer is "Yes," then provide the following information:

   Type of medication:

   Specific work limitation(s):

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2. Have you undergone any operation(s), surgery(s) or hospitalization(s) that limit your current ability to perform the essential physical or mental functions of the position for which you are being considered? ☐ **Yes** ☐ **No**

If your answer is "Yes," then provide the following information:

Date of procedure/hospitalization:

Specific work limitation(s):

3. Has a physician restricted you from performing any physical or mental activities that are necessary to perform the essential job functions of the position for which you are being considered? ☐ **Yes** ☐ **No**

Date Restriction Issued	Name of Physician	Restriction

4. In your opinion, do you need a work-related accommodation for any mental or physical condition that limits your current ability to perform the essential functions of the job for which you are being considered? Such mental or physical conditions may include, but are not limited to, vision or hearing impairments, allergies, skin conditions, dizziness, fainting, loss of consciousness, working in elevated locations, convulsions, seizures, epilepsy, breathing problems, diabetes, headaches, and psychological or emotional disorders. ☐ **Yes** ☐ **No**

If your answer is "Yes," then provide the specific work limitation(s) for the condition you are seeking a work-related accommodation for:

5. Do you experience any chronic pain or musculoskeletal problems that limit your ability to perform the essential functions of the job for which you are being considered? These problems may include, but are not limited to pain, tingling, numbness, limited motion, and limitations in walking, standing, sitting, bending, lifting, and reaching. ☐ **Yes** ☐ **No**

If your answer is "Yes," then check and describe the body part(s) affected:

Neck ☐ Shoulder ☐ Ankle ☐ Wrist ☐ Hand ☐ Back ☐ Hip ☐ Knee ☐ Elbow ☐ Foot ☐

Other:

Please indicate any limitation(s) as a result of your condition:

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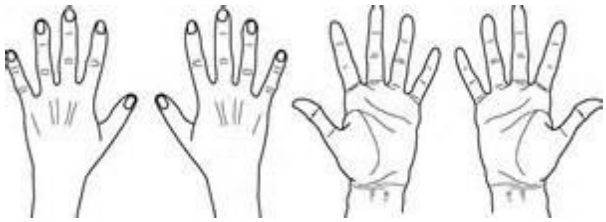
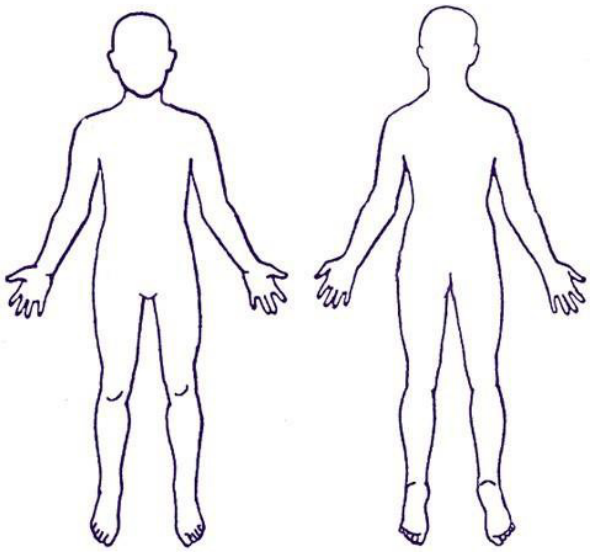
6. Please print this questionnaire to mark on the diagrams where you experience any pain, tingling, numbness, or other problems identified in response to question 5.

XXX
XXX Pain

--- Tingling or numbness





Potentially Hazardous Environment: Please answer the following questions only if the job you applied for requires that you work in an environment where you are likely to come into contact with chemicals or substances (e.g., latex, radiation, lead, paints, glues, dust); or use personal protective gear or equipment. If neither of these requirements applies to the job, then check "N/A" and proceed to the Applicant Certification section.

7. Do you experience any chronic pain or musculoskeletal problems that limit your ability to perform the essential functions of the job for which you are being considered? These problems may include, but are not limited to pain, tingling, numbness, limited motion, and limitations in walking, standing, sitting, bending, lifting, and reaching.

☐ **Yes** ☐ **No** ☐ **N/A**

If your answer is "Yes," then provide the following information:

Chemical(s) or substance(s) sensitive to: _____

Specific work limitation(s): _____

8. Have you ever worked with any of the following? (Check all that apply.)

☐ Asbestos	☐ Noise	☐ Solvents
☐ Dust	☐ Pesticides	☐ Substances that irritated your skin or eyes
☐ Latex	☐ Radiation	☐ Substances that caused breathing difficulties
☐ Lead	☐ Silica powder	☐ N/A

Applicant Certification: *I hereby certify that all of my statements and answers are true and complete. I understand that any misstatement of material fact may subject me to disqualification or dismissal and may cause forfeiture of all rights to employment.*

Applicant's Signature		**Date**	

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EXAMINER INSTRUCTIONS:

1. Please review the questionnaire responses and use this information in conjunction with your physical examination of the applicant to determine the applicant's ability to assume the position sought, with or without the need for a work restriction(s).
2. Maintain this questionnaire in your files. The County is not to receive this questionnaire.
3. Complete the Healthcare Provider's Findings Report on the next page.
4. Send ONLY the Healthcare Provider's Findings Report to OHP.

EXAMINER COMMENTS/NOTES:

Examiner's Name		**Date**	
Examiner's Signature			

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PEPO MEDICAL EXAMINATION
HEALTHCARE PROVIDER'S FINDINGS REPORT

APPLICANT INFORMATION

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Gender		**Date of Birth**		**Age**	
Classification Title				**Item Number**	
Department					
Home Address					
City		**State**		**Zip Code**	
Personal Telephone Number					
Personal Email Address					

CLINIC & APPOINTMENT INFORMATION

Date of Appointment		**Time of Appointment**	
Name of Occupational Health Clinic			

The above-named applicant was evaluated in our clinic, and the following additional information was used to evaluate if this applicant is able to perform the essential functions of the position, from a medical perspective *(check all that apply):*

☐ Applicant-completed Health History Questionnaire dated: ☐

☐ Respirator Questionnaire dated: ☐

☐ Essential Functions Job Analysis ☐ Job Description

☐ Other: ☐

EXAMINER'S DETERMINATION – Please select and initial your choice.

☐ **UNRESTRICTED** – The applicant has no work restrictions and is able to perform the essential functions of this position.

☐ **RESTRICTED** – The applicant was issued the following work restriction(s):

☐

☐

The work restrictions are ☐ Permanent ☐ Temporary through ☐

☐ **INDETERMINATE** – I am unable to make a determination due to the following:

☐

☐

(Do not list any private or protected medical information, including diagnosis, condition, or treatment information)

Examiner's Name		**Date**	
Examiner's Signature			

CLINICS, PLEASE RETURN ONLY THIS PAGE TO OHP