



PRE-PLACEMENT FIREFIGHTER HEALTH HISTORY QUESTIONNAIRE

Applicant instructions:

1. Enter/verify your Applicant Information below.
2. Complete the health questionnaire. 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 position you applied for safely, with or without restrictions. Please fill out the questionnaire completely and accurately.
3. Complete the starred (*) information only on Page 7

Applicant Information. Please provide the following information:

Name (last, first, middle initial): _____

Gender: Male Female

Date of Birth: _____ Last four Digits of Social Security Number: _____

Address: _____

City: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Job Applied For: _____

Health Questionnaire. Please provide the following information. Do not leave any answers blank; use "N/A" if not applicable, or enter "Don't know":

1. List your last three hospitalizations (excluding routine childbirth):

Date	Age	Condition	Name of Hospital	City and State
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. List any other operations or surgeries not included in question 1:

Date	Age	Condition	Name of Hospital	City and State
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Date of last tetanus immunization: _____ Never Unknown

4. List all medications (prescription and nonprescription) you are currently taking (including vitamins, aspirin, antihistamines, cold medications, reducing aids, recreational drugs, etc.): _____

5. List all medications (prescription and nonprescription) not listed above that you have taken in the past two months: _____

6. Do you have, or have you ever had, the following (check all that apply)?

- | | |
|---|---|
| <input type="checkbox"/> Vision problems (eye disease, surgeries, temporary/permanent loss of vision) | <input type="checkbox"/> Cancer, leukemia, or compromised immune system |
| <input type="checkbox"/> Skin condition (recurrent eczema, irritated skin, open lesions) | <input type="checkbox"/> Convulsions/seizures/epilepsy |
| <input type="checkbox"/> Dizziness/fainting/loss of consciousness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Psychological problems/stress/depression | <input type="checkbox"/> Chronic fatigue/Gulf War syndrome |
| <input type="checkbox"/> Prior drug/alcohol treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma/chronic bronchitis/emphysema | <input type="checkbox"/> Pneumothorax |
| <input type="checkbox"/> Bad reaction to cold, heat, heights, or closed spaces | <input type="checkbox"/> Swollen ankles or varicose veins |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Chest pain or heart problems | <input type="checkbox"/> Trouble smelling |
| <input type="checkbox"/> Fractures (broken bones or ribs) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Ulcer/irritable bowel/Crohn's disease | <input type="checkbox"/> Anemia |

Chronic or recurring pain or limited motion associated with:

- Neck Wrist Back Ankle Shoulder Hand Hip Foot Elbow Knee

7. Do you currently use tobacco, or have you used it in the past month? Yes No
8. Have you ever had a reaction, allergy, and/or sensitivity to any drugs (such as codeine, penicillin, or sulfa), latex, foods, plants, or chemicals? Yes No
9. Have you ever had an allergic reaction that affected your breathing? Yes No

If "Yes," please describe: _____

10. Do you currently have any of the following symptoms of pulmonary or lung illness?
- Shortness of breath Yes No
- Shortness of breath when walking fast on level ground or walking up a slight hill or incline Yes No
- Shortness of breath when walking with other people at an ordinary pace on level ground Yes No
- Have to stop for breath when walking at your own pace on level ground Yes No
- Shortness of breath when washing or dressing yourself Yes No
- Shortness of breath that interferes with your job Yes No
- Coughing that produces phlegm (thick sputum) Yes No
- Coughing that wakes you early in the morning Yes No
- Coughing that occurs mostly when you are lying down Yes No
- Coughing up blood in the past month Yes No
- Wheezing Yes No
- Wheezing that interferes with your job Yes No
- Chest pain when you breathe deeply Yes No
- Any other symptoms that you think may be related to lung problems Yes No

If "Yes," please describe: _____

11. Have you ever had any of the following cardiovascular or heart problems?
- High blood pressure Yes No
- Elevated cholesterol Yes No
- Heart murmur Yes No
- Stroke Yes No
- Angina Yes No

- Heart failure Yes No
- Swelling in your legs or feet (not caused by walking) Yes No
- Heart arrhythmia (heart beating irregularly) Yes No
- Heart attack Yes No
- Any other heart problem that you've been told about Yes No

If "Yes," please describe: _____

12. Have you ever had any of the following cardiovascular or heart symptoms?

- Frequent pain or tightness in your chest Yes No
- Pain or tightness in your chest during physical activity Yes No
- Pain or tightness in your chest that interferes with your job Yes No
- Heart skipping or missing a beat in the past two years Yes No
- Heartburn or indigestion that is not related to eating Yes No
- Any other symptoms that you think may be related to heart or circulation problems Yes No

If "Yes," please describe: _____

13. Have you ever had any of the following problems with a respirator?

- Eye irritation Yes No
- Skin allergies or rashes Yes No
- Anxiety or claustrophobia Yes No
- General weakness or fatigue Yes No
- Any other problem that interferes with your use of a respirator Yes No

If "Yes," please describe: _____

14. Are you currently under medical care for any emotional or physical illnesses? Yes No

15. Have you been advised to have any operations that have not yet been done? Yes No

16. Have you ever had a physician or healthcare professional give you activity restrictions? Yes No

If so, are you back on full duty? Yes No

If "No," please describe: _____

17. Do you take medications at work or before work that you believe could affect your physical or mental function or performance? Yes No

18. Have you ever been unable to hold a job or refused employment because of any physical, mental, or other health-related reason? Yes No

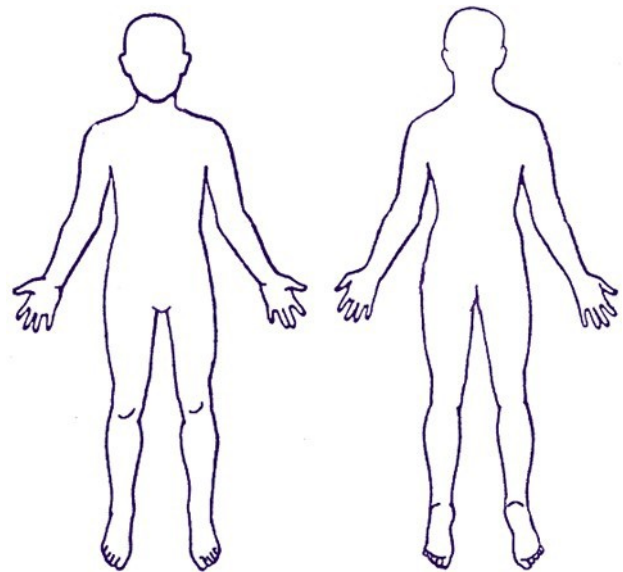
19. Have you ever been rejected or discharged from a military position because of any physical, mental, or other health-related reason? Yes No

20. Within the past year, have you had repeated feelings of numbness, tingling, or "pins and needles" sensations in one or both hands? Yes No

21. Does discomfort in your wrist, arm, or shoulder interfere with your daily activities (eating, writing, sports, etc.) Yes No

22. Please mark on the diagrams where you experience any pain, tingling, numbness, or other problems.

Pain Tingling or numbness



23. Do you currently have any of the following vision problems?

Wear contact lenses Yes No

Wear glasses Yes No

Colorblind Yes No

Any other eye or vision problem Yes No

24. Have you ever had an injury to your ears, including a ruptured eardrum? Yes No

25. Do you currently have any of the following hearing problems?

- Difficulty hearing Yes No
- Wear a hearing aid Yes No
- Any other hearing or ear problem Yes No

26. Have you ever or are you currently being treated for any hazardous or toxic exposure (biological, post-exposure, chemical, physical)? Yes No

27. Have you had any chemical or biological exposures that you know of and/or have concerns? Yes No

28. Relative to this job, is there any health-related condition for which you require accommodation (i.e., job modification or structural changes in work area)? Yes No

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 signature: _____ Date: _____

Physician Instructions:

1. 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 work restrictions.
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. Please **ONLY** send the Healthcare Provider’s Findings Report to OHP.

Physician Signature: _____ Date: _____

Physician Comments/Notes: _____

DO NOT SEND COMPLETED MEDICAL HISTORY QUESTIONNAIRE TO THE COUNTY OF LOS ANGELES



FIREFIGHTER HEALTHCARE PROVIDER'S FINDINGS REPORT

*Applicant Name: _____

*Job Title: _____

*Email Address: _____ *Last Four Digits of SSN: _____ *Phone: _____

*Street Address: _____ *City, State: _____ *Zip: _____

Department Number: _____ Item Number: _____

Date of Birth: _____ Date of Evaluation: _____

Applicant seen at: Westchester Glendale Irwindale Memorial Care

The above-named applicant was evaluated in our clinic, and the following additional information was used to determine if this applicant is able to assume this position, from a physical medical perspective, with or without work restrictions (check all that apply):

- Applicant-completed Health History Questionnaire dated _____
- Respirator Questionnaire dated _____
- Essential Functions Job Analysis
- Job Description
- Other: _____

Physician's determination (please initial your choice):

_____ The applicant has no work restrictions. The applicant is able to perform the essential functions of the position.

_____ 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):

_____ The applicant was issued the following work restrictions:

The work restrictions are: Permanent Temporary through _____ (date)

Physician's Name: _____

Physician's Signature: _____ Date: _____

RETURN ONLY THIS PAGE TO OHP