

RETIREMENT EXEMPTION QUESTIONNAIRE (FIRE DEPT)

OCCUPATIONAL HEALTH PROGRAMS CHIEF EXECUTIVE OFFICE

At the time of your appointment for medical evaluation you must present this questionnaire, completed to the medical/nursing service. To protect your confidentiality, please do not give or show it to anyone else.

NAME (LAST,FIRST, MIDDLE):	LAST 4 SSN:	BIRTHDATE:	AGE:
ADDRESS:	CITY:	STATE, ZIP CODE:	
PRESENT POSITION:	HOME/CELL TELEPHONE: ()	WORK TELEPHONE: ()	

A response is required for each item below. Do not leave any blanks. Be sure to disclose conditions that were treated through the County of LA workers' compensation system. You must explain all "Yes" and "Not Sure" answers on Page 3, and sign at the bottom of Page 3.

Personal Medical History: Have you have ever had any of the following conditions?

Yes	Not Sure	No	
___	___	___	1. Diabetes
___	___	___	2. Head or Brain Injury
___	___	___	3. Kidney Disease
___	___	___	4. Liver Disease
___	___	___	5. Pancreatitis
___	___	___	6. Enlarged Heart
___	___	___	7. Heart Attack
___	___	___	8. Heart Murmur
___	___	___	9. Testing by Harbor Cardiology
___	___	___	10. Heart Valve Abnormality
___	___	___	11. Pain or Discomfort in Chest
___	___	___	12. Heart Failure
___	___	___	13. Palpitation (Irregular Heartbeat)
___	___	___	14. High Blood Pressure
___	___	___	15. Recurrent Dizziness/Lightheadedness
___	___	___	16. Loss of Consciousness
___	___	___	17. Epilepsy
___	___	___	18. Convulsion/Seizure
___	___	___	19. Stroke or Paralysis
___	___	___	20. Missing foot, hand, finger
___	___	___	21. Thyroid Trouble
___	___	___	22. Sleep Apnea
___	___	___	23. Chronic Muscular Disease
___	___	___	24. Chronic Neurological Disease

Review of Symptoms: Do you currently have or have you recently had any of the following?
Please explain all "Yes" and "Not Sure" answers on Page 3.

Yes	Not Sure	No	
_____	_____	_____	25. Difficulty with Night Vision
_____	_____	_____	26. Use of Glasses or Contacts
_____	_____	_____	27. Vision Problem That Has Not Been
_____	_____	_____	28. Recurrent Dizziness
_____	_____	_____	29. Tremors
_____	_____	_____	30. Loss of Coordination
_____	_____	_____	31. Numbness/Tingling of Extremities
_____	_____	_____	32. Inability to Focus
_____	_____	_____	33. Difficulty concentrating
_____	_____	_____	34. Swelling of Feet
_____	_____	_____	35. Leg Pain While Walking
_____	_____	_____	36. Painful Varicose Veins
_____	_____	_____	37. Back Trouble/Pain
_____	_____	_____	38. Neck Trouble/Pain
_____	_____	_____	39. Joint Pain/Swelling
_____	_____	_____	40. Weakness
_____	_____	_____	41. Snoring
_____	_____	_____	42. Difficulty Sleeping
_____	_____	_____	43. Low Blood Sugar

Yes	Not Sure	No	
_____	_____	_____	44. Do you occasionally use, or are you currently taking, any prescription medications? List name, dosage, frequency of use, and the reason for medication on Page 3
_____	_____	_____	45. Have you ever been given permanent restrictions due to a work-related injury or disease?
_____	_____	_____	46. Do you currently have temporary restrictions due to a work-related injury or disease?
_____	_____	_____	47. Do you currently have temporary or permanent restrictions due to a non work-related injury or disease?
_____	_____	_____	48. Do you currently have any physical activity limitations?
_____	_____	_____	49. Has someone ever been concerned about you drinking/drug use or suggested you cut down?
_____	_____	_____	50. Has someone ever been angry/upset about you drinking/drug use?
_____	_____	_____	51. Have you been convicted of driving under the influence (DUI) in the last five years?
_____	_____	_____	52. Have you ever felt bad about your drinking/drug use?
_____	_____	_____	53. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
_____	_____	_____	54. I drink _____beers; _____ounces of hard liquor; _____ounces of wine per week.

