CONFIDENTIAL

CRANE OPERATOR
MEDICAL HISTORY QUESTIONNAIRE

COUNTY OF LOS ANGELES

At the time of your medical appointment, you must present this questionnaire, completed to the medical/nursing service. It is not to be given or shown to anyone else, in order to protect its confidentiality.

NAME (LAST, FIRST, MIDDLE):	EMPLOYEE NUMBER	BIRTHDAY	AGE
ADDRESS:	CITY:	STATE, ZIP CODE	
PRESENT POSITION:	HOME/CELL PHONE ( )	WORK PHONE ( )	

Have you have had any of the following conditions in the last 5 years?

YES	NOT SURE	NO		YES	NOT SURE	NO	
____	____	____	1. Elevated Liver Enzymes	____	____	____	18. Angina
____	____	____	2. Pancreatitis	____	____	____	19. Heart Failure
____	____	____	3. Chronic Neurological Disease	____	____	____	20. Loss of Consciousness
____	____	____	4. Tremors	____	____	____	21. Seizure
____	____	____	5. Loss of Coordination	____	____	____	22. Fainting Spells
____	____	____	6. Transient Ischemic Attack	____	____	____	23. Recurrent Dizziness
____	____	____	7. ADHD	____	____	____	24. Thyroid Trouble
____	____	____	8. Suicide Attempt	____	____	____	25. Sleep Apnea
____	____	____	9. Psychiatric Hospitalization	____	____	____	26. Drug/Alcohol Treatment
____	____	____	10. Manic Episode	____	____	____	27. Muscular Disease
____	____	____	11. Panic Attack	____	____	____	28. Asthma or Lung Disease
____	____	____	12. Low Blood Sugar	____	____	____	29. Kidney Disease
____	____	____	13. Head/brain injury or disorder	____	____	____	30. Liver Disease
____	____	____	14. Heart Disease or Surgery	____	____	____	31. Diabetes
____	____	____	15. High Blood Pressure	____	____	____	32. Stroke or Paralysis
____	____	____	17. Positive Cardiac Stress Test	____	____	____	33. Spinal Injury or Disease

Do you currently have or have you recently had any of the following?

YES	NOT SURE	NO		YES	NOT SURE	NO	
____	____	____	34. Difficulty with Night Vision	____	____	____	43. Irregular Heartbeat
____	____	____	35. Change in Vision	____	____	____	44. Chest Pain
____	____	____	36. Blurred or Double Vision	____	____	____	45. Daytime Sleepiness
____	____	____	37 Blind Spot	____	____	____	46. Snoring
____	____	____	38 Impaired Peripheral Vision	____	____	____	47. Pauses in Breathing while Asleep
____	____	____	39. Hernia				
____	____	____	40. Headaches	____	____	____	48. Shortness of Breath
____	____	____	41. Inability to Focus	____	____	____	49. Low Back Pain
____	____	____	42. Difficulty Concentrating	____	____	____	50. Missing or impaired hand, arm, foot, leg, toe

YES	NOT SURE	NO		
____	____	____	51.	Have you taken any prescription medications or used medical marijuana during the last 6 months? If yes, please list below the name, frequency of use, and reason for the medication.
____	____	____	52.	Do you occasionally use or are you currently taking any over-the-counter medications that carry a warning label regarding drowsiness? If yes, please list below the name, frequency of use, and reason for the medication.
____	____	____	53.	Do you have any limitations or difficulties related to driving?
____	____	____	54.	Has someone ever been concerned about you drinking/drug use?
____	____	____	55.	Has someone ever been angry or upset about you drinking or drug use?
____	____	____	56.	Have you been convicted for driving under the influence (DUI) in the last five years?
____	____	____	57.	Have you ever felt bad about your drinking or drug use?
____	____	____	58.	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

When you have answered "Yes" or "Not Sure", 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)

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 urine and blood testing may be used to detect therapeutic medications to verify my answers. I am aware that any willful inaccuracy may result in disciplinary action.

TYPED OR PRINTED NAME:	COMPLETE SIGNATURE:	DATE: