CONFIDENTIAL

CLANDESTINE LAB MEDICAL HISTORY QUESTIONNAIRE

OCCUPATIONAL HEALTH PROGRAMS
COUNTY OF LOS ANGELES

At the time of your appointment for medical evaluation 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	BIRTHDATE:	AGE:
ADDRESS:	CITY:	STATE, ZIP CODE	
PRESENT POSITION AND DEPARTMENT:	TELEPHONE NO. ( )	WORK TELEPHONE NO. ( )	

Have you have ever had any of the following conditions?

YES	NOT SURE	NO		YES	NOT SURE	NO	
____	____	____	1. Asthma	____	____	____	6. Hepatitis
____	____	____	2. Pneumonia	____	____	____	7. Liver Disease
____	____	____	3. Pneumothorax	____	____	____	9. Pancreatitis
____	____	____	4. Blood Clot in Lungs	____	____	____	8. Elevated Liver Enzyme Test
____	____	____	5. Kidney Disease				

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

YES	NOT SURE	NO		YES	NOT SURE	NO	
____	____	____	10. Frequent Nose Bleeds	____	____	____	20. Tremors
____	____	____	11. Frequent Sinus Trouble	____	____	____	21. Memory Loss
____	____	____	12. Recent Hoarseness	____	____	____	22. Loss of Coordination
____	____	____	13. Shortness of Breath	____	____	____	23. Chest Tightness
____	____	____	14. Chronic or Frequent Cough	____	____	____	24. Wheezing
____	____	____	15. Brown or Blood-Tinged Sputum	____	____	____	25. Currently Pregnant
				____	____	____	26. Infertility
____	____	____	16. Trouble Swallowing	____	____	____	27. Chest Pain
____	____	____	17. Recurrent Dizziness	____	____	____	28. Enlarged Glands
____	____	____	18. Frequent Headaches	____	____	____	29. Rashes
____	____	____	19. Numbness/Tingling of Extremities				

YES	NOT SURE	NO	
____	____	____	30. Do you currently have a cold/cough or have you had any in the last two weeks?
____	____	____	31. Have you inhaled smoke or had a chemical exposure in the last month?
____	____	____	32. Are you a current cigarette smoker? A. How many packs of cigarettes do you smoke a day? _____ B. How long have you been smoking? _____
____	____	____	33. Are you an ex-smoker? A. How many years did you smoke? _____ B. How many packs a day? _____ C. When did you quit? _____

34. I drink ___ beers; ___ ounces of hard liquor; ___ ounces of wine per week.

35. Describe any hobbies or recreational activities that have exposed you to chemicals, or dusty conditions:

_____

SUPPLEMENTAL INFORMATION

When you have answered "Yes" or "Not Sure" to any question, please provide details below including the date of occurrence. Identify each explanation by the corresponding question number.

QUESTION NUMBER	
	(ANY ADDITIONAL INFORMATION, PLEASE USE A SEPARATE SHEET)

I hereby authorize the performance of a complete medical examination and blood testing.

TYPED OR PRINTED NAME:	COMPLETE SIGNATURE:	DATE: