

CONFIDENTIAL

ARMED RESERVE POOL MEDICAL HISTORY QUESTIONNAIRE

OCCUPATIONAL HEALTH PROGRAMS CHIEF EXECUTIVE OFFICE 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:	HOME TELEPHONE NO. ()	WORK TELEPHONE NO. ()	

An answer must be checked for each item. Do not leave any blanks. You must explain all "Yes" and "Not Sure" answers on Page 2. Most individuals will have some "Yes" answers. A "Yes" answer does not necessarily mean that you would be considered medically limited. Check "Yes" for any of the following conditions which you now have or have had in the last ten (10) years. Do not omit conditions treated by Workers' Compensation.

Yes	Not Sure	No		Yes	Not Sure	No	
___	___	___	1. Asthma	___	___	___	21. Heart Failure
___	___	___	2. Shortness of Breath	___	___	___	22. Swelling of Feet
___	___	___	3. Worn Glasses/Lenses	___	___	___	23. High Blood Pressure
___	___	___	4. Cataract	___	___	___	24. Epilepsy
___	___	___	5. Blurred or Double Vision	___	___	___	25. Convulsion/Seizure
___	___	___	6. Glaucoma	___	___	___	26. Fainting Spell
___	___	___	7. Diabetes	___	___	___	27. Recurrent Dizziness
___	___	___	8. Low Blood Sugar	___	___	___	28. Stroke
___	___	___	9. Thyroid Disease	___	___	___	29. Tremors
___	___	___	10. Kidney Disease	___	___	___	30. Chronic Neurological Disease
___	___	___	11. Liver Disease	___	___	___	31. Loss of Consciousness
___	___	___	12. Hernia	___	___	___	32. Back Trouble/Pain
___	___	___	13. Currently Pregnant	___	___	___	33. Neck Trouble/Pain
___	___	___	14. Heart Attack	___	___	___	34. Numbness of Extremities
___	___	___	15. Heart Murmur	___	___	___	35. Arthritis/Rheumatism
___	___	___	16. Palpitation (Irregular Heartbeat)	___	___	___	36. Elbow Injury/Pain
___	___	___	17. Heart Valve Abnormality	___	___	___	37. Wrist/Hand Injury/Pain
___	___	___	18. Positive Cardiac Stress Test	___	___	___	38. Hip Injury/Pain
___	___	___	19. Enlarged Heart	___	___	___	39. Knee Injury Pain
___	___	___	20. Pain or Discomfort in Chest	___	___	___	40. Carpal Tunnel Syndrome

42. Do you have any physical activity limitations?

ACTIVITY	HOW MANY HOURS DO YOU SPEND DOING THIS PER WEEK?	HOW MANY MONTHS/YEARS HAVE YOU BEEN DOING THIS?
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When you have answered “Yes” or “Not Sure” to any question on this form, write the details in the space below. Identify each explanation by the corresponding number. Explain in detail your medical condition. Include the date of occurrence.

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

clearance for this special assignment and/or disciplinary action.		
TYPED OR PRINTED NAME:	COMPLETE SIGNATURE:	DATE:
NAMES USED IN THE PAST, INCLUDING MAIDEN NAME (IF APPLICABLE):		