

FITNESS-FOR-LIFE PROGRAM MEDICAL HISTORY QUESTIONNAIRE

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 should not be given or shown to anyone else to protect confidentiality.

NAME (LAST, FIRST, MIDDLE):	LAST 4 SSN	BIRTHDAY	AGE
ADDRESS:	CITY:	STATE, ZIP CODE	
PRESENT POSITION:	CELL ()	WORK PHONE ()	

In order for you to gain the most benefit from the Wellness program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, it may be left blank. Please explain all "Yes" and "Not Sure" answers on page 5.

Have you ever had any of the following conditions?

YES	NOT SURE	NO		YES	NOT SURE	NO	
_____	_____	_____	1. Loss of Hearing	_____	_____	_____	18. Angina
_____	_____	_____	2. Asthma	_____	_____	_____	19. Heart Failure
_____	_____	_____	3. Pneumonia	_____	_____	_____	20. Thickened Heart Muscle
_____	_____	_____	4. Pneumothorax	_____	_____	_____	21. Atrial Fibrillation
_____	_____	_____	5. Blood Clot in Lungs	_____	_____	_____	22. Myocarditis (Heart Infection)
_____	_____	_____	6. Kidney Disease	_____	_____	_____	23. High Cholesterol
_____	_____	_____	7. Prostatitis	_____	_____	_____	24. High Blood Pressure
_____	_____	_____	8. Colitis	_____	_____	_____	25. Stroke
_____	_____	_____	9. Hepatitis	_____	_____	_____	26. Epilepsy
_____	_____	_____	10. Liver Disease	_____	_____	_____	27. Diabetes
_____	_____	_____	11. Elevated Liver Enzymes	_____	_____	_____	28. Thyroid Trouble
_____	_____	_____	12. Pancreatitis	_____	_____	_____	29. Anemia
_____	_____	_____	13. Ulcer	_____	_____	_____	30. Arthritis/Rheumatism
_____	_____	_____	14. Heart Attack	_____	_____	_____	31. Cancer (including Skin)
_____	_____	_____	15. Heart Murmur	_____	_____	_____	32. Sleep Apnea
_____	_____	_____	16. Positive Stress Test	_____	_____	_____	33. Chronic Muscular Disease
_____	_____	_____	17. Heart Valve Abnormality	_____	_____	_____	34. Chronic Neurological Disease

Please explain all "Yes" and "Not Sure" answers on page 5.

Do you currently have or have had in the last year any of the following? Please explain all "Yes" and "Not Sure" answers on page 5.

YES	NOT SURE	NO		YES	NOT SURE	NO	
_____	_____	_____	35. Difficulty with Night Vision	_____	_____	_____	63. Black or Bloody Bowel Movement
_____	_____	_____	36. Change in Vision	_____	_____	_____	64. Hemorrhoids
_____	_____	_____	37. Blurred or Double Vision	_____	_____	_____	65. Trouble Swallowing
_____	_____	_____	38. Bleeding Gums	_____	_____	_____	66. Hernia
_____	_____	_____	39. Frequent Nose Bleeds	_____	_____	_____	67. Loss of Consciousness
_____	_____	_____	40. Frequent Sinus Trouble	_____	_____	_____	68. Recurrent Dizziness
_____	_____	_____	41. Recent Hoarseness	_____	_____	_____	69. Frequent Headaches
_____	_____	_____	42. Ringing/Buzzing Ears	_____	_____	_____	70. Tremors
_____	_____	_____	43. Ear Aches	_____	_____	_____	71. Memory Loss
_____	_____	_____	44. Shortness of Breath	_____	_____	_____	72. Loss of Coordination
_____	_____	_____	45. Chronic or Frequent Cough	_____	_____	_____	73. Numbness/Tingling of Extremities
_____	_____	_____	46. Brown or Blood-Tinged Sputum	_____	_____	_____	74. Anxiety
_____	_____	_____	47. Wheezing	_____	_____	_____	75. Depression
_____	_____	_____	48. Bladder Trouble	_____	_____	_____	76. Irregular Heartbeat
_____	_____	_____	49. Blood in Urine	_____	_____	_____	77. Chest Pain or Tightness
_____	_____	_____	50. Irregular Vaginal Bleeding	_____	_____	_____	78. Swelling of Feet
_____	_____	_____	51. Pregnancy	_____	_____	_____	79. Leg Pain While Walking
_____	_____	_____	52. Difficulty Starting or Stopping Urination	_____	_____	_____	80. Painful Varicose Veins
_____	_____	_____	53. Urinating 3 Times Per Night	_____	_____	_____	81. Joint Pain/Swelling
_____	_____	_____	54. Frequent or Painful Urination	_____	_____	_____	82. Undesired Weight Loss
_____	_____	_____	55. Problems with Sexual Function	_____	_____	_____	83. Undesired Weight Gain
_____	_____	_____	56. Infertility	_____	_____	_____	84. Bleeding/Bruising Easily
_____	_____	_____	57. Vomited Blood	_____	_____	_____	85. Enlarged Glands
_____	_____	_____	58. Persistent Diarrhea	_____	_____	_____	86. Rashes
_____	_____	_____	59. Persistent Constipation	_____	_____	_____	87. Unexplained Lumps
_____	_____	_____	60. Frequent Abdominal Pain	_____	_____	_____	88. Chronic Fatigue
_____	_____	_____	61. Frequent Nausea	_____	_____	_____	89. Night Sweats
_____	_____	_____	62. Frequent Indigestion or Heartburn	_____	_____	_____	90. Snoring
				_____	_____	_____	91. Difficulty sleeping
				_____	_____	_____	92. Low Blood Sugar

Please explain all "Yes" and "Not Sure" answers on page 5.

YES	NOT SURE	NO	
_____	_____	_____	Please explain all "Yes" and "Not Sure" answers on page 5.
_____	_____	_____	93. Are you experiencing any stresses, mood problems, financial problems, relationships difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
_____	_____	_____	94. Have you been absent from work due to stress in the past year?
_____	_____	_____	95. Have you had any surgical operations in the last 5 years?
_____	_____	_____	96. Do you currently have a cold/cough or have you had any in the last two weeks?
_____	_____	_____	97. Have you inhaled smoke in the last 24 hours?
_____	_____	_____	98. Have you been hospitalized in the last 5 years? If "yes", list date, length of stay, and reason on page 5.
_____	_____	_____	99. Are you currently under a doctor's care? If yes, please describe what you are being treated for on page 5.
_____	_____	_____	100. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
_____	_____	_____	101. Have you been exposed to loud noise today?
_____	_____	_____	102. Is there any medical reason for you to not complete your treadmill, strength, or flexibility measurements today?
_____	_____	_____	103. Are you a current cigarette smoker?
			A. How many packs of cigarettes do you smoke a day? _____
			B. How long have you been smoking? _____
_____	_____	_____	104. Are you an ex-smoker?
			A. How many years did you smoke? _____
			B. How many packs a day? _____
			C. When did you quit? _____
_____	_____	_____	105. Have you used chewing tobacco or smoked cigars or pipe in the last 15 years?
_____	_____	_____	106. Has someone ever been concerned about your drinking or suggested you cut down?
_____	_____	_____	107. Has someone ever been angry or upset about you drinking?
_____	_____	_____	108. Have you been convicted for driving under the influence (DUI) in the last five years?
_____	_____	_____	109. Have you ever felt bad about your drinking?
_____	_____	_____	110. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Please explain all "Yes" and "Not Sure" answers on page 5.

111. I drink ____ beers; ____ ounces of hard liquor; ____ ounces of wine per week.

112. Men age 50 or more: Date of last colonoscopy _____ Findings _____

113. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

114. Have you taken any prescription medications during the last 6 months? Please give details below.

NAME	TAKEN HOW OFTEN?	REASON FOR MEDICATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

115. Please describe your typical on-duty and off-duty exercise including any flexibility training:

ACTIVITY:	HOURS PER WEEK?	HOW LONG HAVE YOU BEEN DOING THIS ACTIVITY?	
_____	_____	____ Months	____ Years
_____	_____	____ Months	____ Years
_____	_____	____ Months	____ Years
_____	_____	____ Months	____ Years

116. Do you get any symptoms with these activities such as chest, arm, or neck pain, chest tightness, lightheadedness, irregular heart rate, or palpitations?

____ No ____ Yes (Please explain on Page 5)

117. Are you on any special diet?

____ No ____ Yes (Please explain): _____

SUPPLEMENTAL INFORMATION

When you have answered "Yes" or "Not Sure" to any question on this form, 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)