CONFIDENTIAL

EXECUTIVE HEALTH
MEDICAL HISTORY QUESTIONNAIRE

OCCUPATIONAL HEALTH PROGRAM
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:	HOME TELEPHONE ( )	WORK TELEPHONE ( )	

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all "Yes" answers on page 4.

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

YES	NO		YES	NO	
___	___	1. Allergies	___	___	16. Angina
___	___	2. Loss of Hearing	___	___	17. Heart Failure
___	___	3 Asthma	___	___	18. High Cholesterol
___	___	4. Kidney Disease	___	___	19. High Blood Pressure
___	___	5. Prostatitis	___	___	20. Arthritis/Rheumatism
___	___	6. Colitis	___	___	21. Loss of Consciousness
___	___	7. Hepatitis	___	___	22. Epilepsy
___	___	8. Liver Disease	___	___	23. Convulsions/Seizures
___	___	9. Elevated Liver Enzyme Test	___	___	24. Stroke
___	___	10. Pancreatitis	___	___	25. Diabetes
___	___	11. Ulcer	___	___	26. Thyroid Trouble
___	___	12. Heart Attack	___	___	27. Anemia
___	___	13. Heart Murmur	___	___	28. Eczema
___	___	14. Positive Stress Test	___	___	29. Cancer (including Skin Cancer)
___	___	15. Heart Valve Abnormality	___	___	30. Sleep Apnea

Review of Symptoms: Do you currently have or have you recently had any of the following? : Please explain all "Yes" answers on page 4.

YES NO

EYES, EARS, NOSE, THROAT

___ ___ 31. Difficulty with Night Vision
___ ___ 32. Change in Vision
___ ___ 33. Blurred or Double Vision
___ ___ 34. Bleeding Gums
___ ___ 35. Frequent Nose Bleeds
___ ___ 36. Frequent Sinus Trouble
___ ___ 37. Recent Hoarseness
___ ___ 38. Ringing/Buzzing Ears
___ ___ 39. Ear Aches

PULMONARY

___ ___ 40. Shortness of Breath
___ ___ 41. Chronic or Frequent Cough
___ ___ 42. Brown or Blood-Tinged Sputum
___ ___ 43. Chest Tightness
___ ___ 44. Wheezing

GENITO-URINARY

___ ___ 45. Bladder Trouble
___ ___ 46. Blood in Urine
___ ___ 47. Irregular Vaginal Bleeding
___ ___ 48. Currently Pregnant
___ ___ 49. Difficulty Starting or Stopping Urination
___ ___ 50. Urinating 3 Times Per Night
___ ___ 51. Frequent or Painful Urination
___ ___ 52. Problems with Sexual Function

GASTROINTESTINAL

___ ___ 53. Vomited Blood
___ ___ 54. Persistent Diarrhea
___ ___ 55. Persistent Constipation
___ ___ 56. Frequent Abdominal Pain
___ ___ 57. Frequent Nausea
___ ___ 58. Frequent Indigestion/Heartburn
___ ___ 59. Black or Bloody Bowel Movement
___ ___ 60. Hemorrhoids
___ ___ 61. Trouble Swallowing
___ ___ 62. Hernia

YES NO

CENTRAL NERVOUS SYSTEM

___ ___ 63. Fainting Spells
___ ___ 64. Recurrent Dizziness
___ ___ 65. Frequent Headaches
___ ___ 66. Tremors
___ ___ 67. Memory Loss
___ ___ 68. Loss of Coordination
___ ___ 69. Difficulty Concentrating
___ ___ 70. Numbness/Tingling of Extremities

HEART/VASCULAR

___ ___ 71. Palpitation (Irreg. Heartbeat)
___ ___ 72. Pain or Discomfort in Chest
___ ___ 73. High Cholesterol
___ ___ 74. Swelling of Feet
___ ___ 75. Leg Pain While Walking
___ ___ 76. Painful Varicose Veins

MUSCULO/SKELETAL.

___ ___ 77. Back Trouble/Pain
___ ___ 78. Neck Trouble/Pain
___ ___ 79. Joint Injury/Pain/Swelling
___ ___ 80. Carpal Tunnel Syndrome

MISCELLANEOUS

___ ___ 81. Bleeding/Bruising Easily
___ ___ 82. Enlarged Glands
___ ___ 83. Rashes
___ ___ 84. Unexplained Lumps
___ ___ 85. Chronic Fatigue
___ ___ 86. Night Sweats
___ ___ 87. Undesired Weight Loss
___ ___ 88. Snoring
___ ___ 89. Difficulty sleeping
___ ___ 90. Low Blood Sugar

YES NO **Please explain all "Yes" answers on page 4.**

___ ___ 91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
___ ___ 92. Do you occasionally use or are you currently taking any prescription or over the counter medications? List name, dosage, and the reason the medication is used on page 4.
___ ___ 93. Have you had any surgical operations in the last 10 years?
___ ___ 94. Has anyone in your immediate family developed heart disease before the age of 60?
___ ___ 95. Do any diseases run in your family?
___ ___ 96. Do you currently have a cold/cough or have you had any in the last two weeks?
___ ___ 97. Have you ever been hospitalized? If "yes", list date, length of stay, and reason on pg 4.
___ ___ 98. Are you currently under a doctor's care? If yes, please describe what you are being treated for on page 4.
___ ___ 99. Have you ever been advised by an Executive Medical Program or County physician to see your private physician to follow-up on a problem?
___ ___ 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. Do you have any special concerns regarding your health that you would like to discuss with the doctor today?
___ ___ 102. Are you a current cigarette smoker?
A. How many packs of cigarettes do you smoke a day? _____
B. How long have you been smoking? _____
___ ___ 103. Are you an ex-smoker?
A. How many years did you smoke? _____
B. How many packs a day? _____
C. When did you quit? _____
___ ___ 104. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

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

106. When were your most recent immunizations?:

Tetanus _____ Flu shot _____ Pneumovax _____

107. When were you most recent health maintenance screening tests?:

Cholesterol _____ Results? _____ PSA (Prostate) _____ Results?_____
Mammogram_____ Results? _____ Sigmoidoscopy _____ Results?_____
Pap Smear _____ Results? _____

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

109. Please describe typical weekly exercise or physical activities including any exercise at work:
_____

110. My current diet could be best characterized as (check all that apply):

____ Low fat ___ Low carb ___ High protein ___ Vegetarian/Vegan ____No special diet

SUPPLEMENTAL INFORMATION

When you have answered "yes" 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 including dates of occurrence.

QUESTION NUMBER	
	(If Needed, Please Attach An Additional Sheet)

I hereby authorize the performance of a complete medical examination, x-rays, blood testing, and urine testing. However, urine testing shall not include testing for illegal substances.

TYPED OR PRINTED NAME:	COMPLETE SIGNATURE:	DATE:
NAMES USED IN THE PAST, INCLUDING MAIDEN NAME (IF APPLICABLE):		