

CONFIDENTIAL

WELLNESS 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 is not to be given or shown to anyone else, in order to protect its confidentiality.

NAME (LAST, FIRST, MIDDLE):	SOC SEC NUMBER	BIRTHDAY	AGE
ADDRESS:	CITY:	STATE, ZIP CODE	
PRESENT POSITION:	HOME PHONE NO. (     )	WORK PHONE NO. (     )	

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. However, **if you are a certified HAZMAT technician or specialist, you must answer all questions preceded by an asterisk (\*). Failure to answer these questions may result in restrictions against HAZMAT work.** Please explain all "Yes" answers on page 5.

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

YES NO

- \_\_\_ \_\_\_ 1. Loss of Hearing
- \_\_\_ \_\_\_ 2. \*Asthma
- \_\_\_ \_\_\_ 3. \*Pneumonia
- \_\_\_ \_\_\_ 4. \*Pneumothorax
- \_\_\_ \_\_\_ 5. \*Blood Clot in Lungs
- \_\_\_ \_\_\_ 6. \*Kidney Disease
- \_\_\_ \_\_\_ 7. Prostatitis
- \_\_\_ \_\_\_ 8. Colitis
- \_\_\_ \_\_\_ 9. \*Hepatitis
- \_\_\_ \_\_\_ 10. \*Liver Disease
- \_\_\_ \_\_\_ 11. \*Elevated Liver Enzyme Test
- \_\_\_ \_\_\_ 12. Pancreatitis
- \_\_\_ \_\_\_ 13. Ulcer
- \_\_\_ \_\_\_ 14. \*Heart Attack
- \_\_\_ \_\_\_ 15. Heart Murmur
- \_\_\_ \_\_\_ 16. \*Positive Stress Test
- \_\_\_ \_\_\_ 17. Heart Valve Abnormality

YES NO

- \_\_\_ \_\_\_ 18. \*Angina
- \_\_\_ \_\_\_ 19. \*Heart Failure
- \_\_\_ \_\_\_ 20. High Cholesterol
- \_\_\_ \_\_\_ 21. \*High Blood Pressure
- \_\_\_ \_\_\_ 22. Arthritis/Rheumatism
- \_\_\_ \_\_\_ 23. Loss of Consciousness
- \_\_\_ \_\_\_ 24. Epilepsy
- \_\_\_ \_\_\_ 25. Convulsions/Seizures
- \_\_\_ \_\_\_ 26. Stroke
- \_\_\_ \_\_\_ 27. Diabetes
- \_\_\_ \_\_\_ 28. Thyroid Trouble
- \_\_\_ \_\_\_ 29. Anemia
- \_\_\_ \_\_\_ 30. Eczema
- \_\_\_ \_\_\_ 31. Cancer (including Skin Cancer)
- \_\_\_ \_\_\_ 32. Sleep Apnea
- \_\_\_ \_\_\_ 33. Chronic Muscular Disease
- \_\_\_ \_\_\_ 34. Chronic Neurological Disease

**Review of Symptoms:** Do you currently have or have you recently had any of the following?:  
Please explain all "Yes" answers on page 5.

YES NO

EYES, EARS, NOSE, THROAT

- \_\_\_ \_\_\_ 35. Difficulty with Night Vision  
 \_\_\_ \_\_\_ 36. Change in Vision  
 \_\_\_ \_\_\_ 37. Blurred or Double Vision  
 \_\_\_ \_\_\_ 38. Bleeding Gums  
 \_\_\_ \_\_\_ 39. Frequent Nose Bleeds  
 \_\_\_ \_\_\_ 40. Frequent Sinus Trouble  
 \_\_\_ \_\_\_ 41. Recent Hoarseness  
 \_\_\_ \_\_\_ 42. Ringing/Buzzing Ears  
 \_\_\_ \_\_\_ 43. Ear Aches

PULMONARY

- \_\_\_ \_\_\_ 44. \*Shortness of Breath  
 \_\_\_ \_\_\_ 45. \*Chronic or Frequent Cough  
 \_\_\_ \_\_\_ 46. Brown or Blood-Tinged Sputum  
 \_\_\_ \_\_\_ 47. \*Chest Tightness  
 \_\_\_ \_\_\_ 48. \*Wheezing

GENITO-URINARY

- \_\_\_ \_\_\_ 49. Bladder Trouble  
 \_\_\_ \_\_\_ 50. Blood in Urine  
 \_\_\_ \_\_\_ 51. Irregular Vaginal Bleeding  
 \_\_\_ \_\_\_ 52. \*Currently Pregnant  
 \_\_\_ \_\_\_ 53. Difficulty Starting or Stopping  
 Urination  
 \_\_\_ \_\_\_ 54. Urinating 3 Times Per Night  
 \_\_\_ \_\_\_ 55. Frequent or Painful Urination  
 \_\_\_ \_\_\_ 56. Problems with Sexual Function  
 \_\_\_ \_\_\_ 57. Infertility

GASTROINTESTINAL

- \_\_\_ \_\_\_ 58. Vomited Blood  
 \_\_\_ \_\_\_ 59. Persistent Diarrhea  
 \_\_\_ \_\_\_ 60. Persistent Constipation  
 \_\_\_ \_\_\_ 61. Frequent Abdominal Pain  
 \_\_\_ \_\_\_ 62. Frequent Nausea  
 \_\_\_ \_\_\_ 63. Frequent Indigestion/Heartburn  
 \_\_\_ \_\_\_ 64. Black or Bloody Bowel Movement  
 \_\_\_ \_\_\_ 65. Hemorrhoids  
 \_\_\_ \_\_\_ 66. Trouble Swallowing  
 \_\_\_ \_\_\_ 67. Hernia

YES NO

CENTRAL NERVOUS SYSTEM

- \_\_\_ \_\_\_ 68. Fainting Spells  
 \_\_\_ \_\_\_ 69. Recurrent Dizziness  
 \_\_\_ \_\_\_ 70. Frequent Headaches  
 \_\_\_ \_\_\_ 71. Tremors  
 \_\_\_ \_\_\_ 72. Memory Loss  
 \_\_\_ \_\_\_ 73. Loss of Coordination  
 \_\_\_ \_\_\_ 74. Numbness/Tingling of Extremities

MENTAL HEALTH

- \_\_\_ \_\_\_ 75. Recurrent Nightmares  
 \_\_\_ \_\_\_ 76. Intrusive Images  
 \_\_\_ \_\_\_ 77. Inability to Focus  
 \_\_\_ \_\_\_ 78. Difficulty Concentrating  
 \_\_\_ \_\_\_ 79. Anxiety  
 \_\_\_ \_\_\_ 80. Panic Attacks  
 \_\_\_ \_\_\_ 81. Depression

HEART/VASCULAR

- \_\_\_ \_\_\_ 82. Palpitation (Irreg. Heartbeat)  
 \_\_\_ \_\_\_ 83. Pain or Discomfort in Chest  
 \_\_\_ \_\_\_ 84. Swelling of Feet  
 \_\_\_ \_\_\_ 85. Leg Pain While Walking  
 \_\_\_ \_\_\_ 86. Painful Varicose Veins

MUSCULO/SKELETAL

- \_\_\_ \_\_\_ 87. Back Trouble/Pain  
 \_\_\_ \_\_\_ 88. Neck Trouble/Pain  
 \_\_\_ \_\_\_ 89. Joint Injury/Pain/Swelling  
 \_\_\_ \_\_\_ 90. Carpal Tunnel Syndrome

MISCELLANEOUS

- \_\_\_ \_\_\_ 91. Bleeding/Bruising Easily  
 \_\_\_ \_\_\_ 92. Enlarged Glands  
 \_\_\_ \_\_\_ 93. Rashes  
 \_\_\_ \_\_\_ 94. Unexplained Lumps  
 \_\_\_ \_\_\_ 95. Chronic Fatigue  
 \_\_\_ \_\_\_ 96. Night Sweats  
 \_\_\_ \_\_\_ 97. Undesired Weight Loss  
 \_\_\_ \_\_\_ 98. Snoring  
 \_\_\_ \_\_\_ 99. Difficulty sleeping  
 \_\_\_ \_\_\_ 100. Low Blood Sugar

YES NO

**Please explain all "Yes" answers on page 5.**

- \_\_\_ \_\_\_ 101. Are you experiencing any stresses, mood problems, financial problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis?
- \_\_\_ \_\_\_ 102. Have you been absent from work due to stress in the past year?
- \_\_\_ \_\_\_ 103. \*Do you occasionally use or are you currently taking any prescription or over the counter medications? List name, dosage, frequency of use, and the reason the medication is used on page 5.
- \_\_\_ \_\_\_ 104. Have you had any surgical operations in the last 10 years?
- \_\_\_ \_\_\_ 105. Has anyone in your immediate family developed heart disease before the age of 60?
- \_\_\_ \_\_\_ 106. \*Do you currently have a cold/cough or have you had any in the last two weeks?
- \_\_\_ \_\_\_ 107. \*Have you inhaled smoke in the last 24 hours?
- \_\_\_ \_\_\_ 108. Have you been hospitalized in the last 10 years? If "yes", list date, length of stay, and reason on page 5.
- \_\_\_ \_\_\_ 109. \*Are you currently under a doctor's care? If yes, please describe what you are being treated for on page 5.
- \_\_\_ \_\_\_ 110. Have you ever been advised by a Wellness Program or County physician to see your private physician to follow-up on a problem?
- \_\_\_ \_\_\_ 111. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
- \_\_\_ \_\_\_ 112. Have you been exposed to loud noise today?
- \_\_\_ \_\_\_ 113. \*Do you have any physical activity limitations or difficulties performing firefighting tasks?
- \_\_\_ \_\_\_ 114. Is there any medical reason for you to not complete your treadmill, strength, and/or flexibility measurements today?
- \_\_\_ \_\_\_ 115. \*Are you a current cigarette smoker?  
 A. How many packs of cigarettes do you smoke a day? \_\_\_\_\_  
 B. How long have you been smoking? \_\_\_\_\_
- \_\_\_ \_\_\_ 116. \*Are you an ex-smoker?  
 A. How many years did you smoke? \_\_\_\_\_  
 B. How many packs a day? \_\_\_\_\_  
 C. When did you quit? \_\_\_\_\_
- \_\_\_ \_\_\_ 117. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?
- \_\_\_ \_\_\_ 118. Has someone ever been concerned about you drinking/drug use or suggested you cut down?
- \_\_\_ \_\_\_ 119. Has someone ever been angry/upset about you drinking/drug use?
- \_\_\_ \_\_\_ 120. Have you been convicted for driving under the influence (DUI) in the last five years?
- \_\_\_ \_\_\_ 121. Have you ever felt bad about your drinking/drug use?
- \_\_\_ \_\_\_ 122. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

123. \*I drink \_\_\_\_ beers; \_\_\_\_ ounces of hard liquor; \_\_\_\_ ounces of wine per week.

124. When were your last immunizations?

Tetanus \_\_\_\_\_ Flu shot \_\_\_\_\_ Hepatitis B \_\_\_\_\_

125. When were your most recent health maintenance screening tests?:

Cholesterol \_\_\_\_\_ Results? \_\_\_\_\_

Hep B Titer \_\_\_\_\_ Results? \_\_\_\_\_

Mammogram \_\_\_\_\_ Results? \_\_\_\_\_

Pap Smear \_\_\_\_\_ Results? \_\_\_\_\_

PSA (Prostate) \_\_\_\_\_ Results? \_\_\_\_\_

Sigmoidoscopy \_\_\_\_\_ Results? \_\_\_\_\_

126 My last chest x-ray was in \_\_\_\_\_(year).

127. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dusty conditions: \_\_\_\_\_

128. Please describe your typical on-duty and off-duty exercise habits including cardiovascular, strength, and flexibility training:

ACTIVITY	HOW MUCH TIME DO YOU SPEND DOING THIS ACTIVITY PER WEEK?	HOW MANY MONTHS/YEARS HAVE YOU BEEN DOING THIS ACTIVITY?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Low fat     Low carb     High protein  
 Vegetarian/Vegan     No special diet

