RETIREMENT EXEMPTION QUESTIONNAIRE (FIRE DEPT)

OCCUPATIONAL HEALTH PROGRAMS
CHIEF EXECUTIVE OFFICE

At the time of your appointment for medical evaluation you must present this questionnaire, completed to the medical/nursing service. To protect your confidentiality, please do not give or show it to anyone else.

NAME (LAST,FIRST, MIDDLE):	LAST 4 SSN:	BIRTHDATE:	AGE:
ADDRESS:	CITY:	STATE, ZIP CODE:	
PRESENT POSITION:	HOME/CELL TELEPHONE: ( )	WORK TELEPHONE: ( )	

A response is required for each item below. Do not leave any blanks. Be sure to disclose conditions that were treated through the County of LA workers' compensation system. You must explain all "Yes" and "Not Sure" answers on Page 3, and sign at the bottom of Page 3.

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

Yes	Not Sure	No	
___	___	___	1. Diabetes
___	___	___	2. Head or Brain Injury
___	___	___	3. Kidney Disease
___	___	___	4. Liver Disease
___	___	___	5. Pancreatitis
___	___	___	6. Enlarged Heart
___	___	___	7. Heart Attack
___	___	___	8. Heart Murmur
___	___	___	9. Testing by Harbor Cardiology
___	___	___	10. Heart Valve Abnormality
___	___	___	11. Pain or Discomfort in Chest
___	___	___	12. Heart Failure
___	___	___	13. Palpitation (Irregular Heartbeat)
___	___	___	14. High Blood Pressure
___	___	___	15. Recurrent Dizziness/Lightheadedness
___	___	___	16. Loss of Consciousness
___	___	___	17. Epilepsy
___	___	___	18. Convulsion/Seizure
___	___	___	19. Stroke or Paralysis
___	___	___	20. Missing foot, hand, finger
___	___	___	21. Thyroid Trouble
___	___	___	22. Sleep Apnea
___	___	___	23. Chronic Muscular Disease
___	___	___	24. Chronic Neurological Disease

Review of Symptoms: Do you currently have or have you recently had any of the following? Please explain all "Yes" and "Not Sure" answers on Page 3.

Yes	Not Sure	No	
____	____	____	25. Difficulty with Night Vision
____	____	____	26. Use of Glasses or Contacts
____	____	____	27. Vision Problem That Has Not Been
____	____	____	28. Recurrent Dizziness
____	____	____	29. Tremors
____	____	____	30. Loss of Coordination
____	____	____	31. Numbness/Tingling of Extremities
____	____	____	32. Inability to Focus
____	____	____	33. Difficulty concentrating
____	____	____	34. Swelling of Feet
____	____	____	35. Leg Pain While Walking
____	____	____	36. Painful Varicose Veins
____	____	____	37. Back Trouble/Pain
____	____	____	38. Neck Trouble/Pain
____	____	____	39. Joint Pain/Swelling
____	____	____	40. Weakness
____	____	____	41. Snoring
____	____	____	42. Difficulty Sleeping
____	____	____	43. Low Blood Sugar

Yes	Not Sure	No	
___	___	___	44. Do you occasionally use, or are you currently taking, any prescription medications? List name, dosage, frequency of use, and the reason for medication on Page 3
___	___	___	45. Have you ever been given permanent restrictions due to a work-related injury or disease?
___	___	___	46. Do you currently have temporary restrictions due to a work-related injury or disease?
___	___	___	47. Do you currently have temporary or permanent restrictions due to a non work-related injury or disease?
___	___	___	48. Do you currently have any physical activity limitations?
___	___	___	49. Has someone ever been concerned about you drinking/drug use or suggested you cut down?
___	___	___	50. Has someone ever been angry/upset about you drinking/drug use?
___	___	___	51. Have you been convicted of driving under the influence (DUI) in the last five years?
___	___	___	52. Have you ever felt bad about your drinking/drug use?
___	___	___	53. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
___	___	___	54. I drink ____beers; _____ounces of hard liquor; ____ounces of wine per week.

56. Please describe your typical weekly exercise or physical activity:

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

SUPPLEMENTAL INFORMATION

If you have answered "Yes" or "Not Sure" to any questions, please provide detailed information in the space below:

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

I declare that my answers are true to the best of my knowledge and belief. I am aware that willful misrepresentation may result in non-certification for continued employment past age 60.

TYPED OR PRINTED NAME OF EMPLOYEE:	COMPLETE SIGNATURE:	DATE: