CONFIDENTIAL

CONFINED SPACE MEDICAL HISTORY QUESTIONNAIRE

OCCUPATIONAL HEALTH PROGRAMS
COUNTY OF LOS ANGELES

NAME (LAST,FIRST, MIDDLE):	EMPLOYEE NUMBER	BIRTHDATE:	AGE:
ADDRESS:	CITY:	STATE, ZIP CODE	
PRESENT POSITION AND DEPARTMENT:	HOME TELEPHONE NO. ( )	WORK TELEPHONE NO. ( )	

A "Yes" or "No" must be checked for each item. Check "Yes" for any of the following conditions which you now have or have had in the last five (5) years.

YES NO
___ ___ 1. Heart Attack
___ ___ 2. Pain or Discomfort in Chest
___ ___ 3. Palpitation (Irregular Heartbeat)
___ ___ 4 Low Blood Sugar.
___ ___ 5. Diabetes

YES NO
___ ___ 6. Convulsion
___ ___ 7. Fainting Spell
___ ___ 8. Recurrent Dizziness/Lightheaded
___ ___ 9. Loss of Consciousness
___ ___ 10. Seizure

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 the date of occurrence.

QUESTION NUMBER	