COUNTY OF LOS ANGELES
Department of Human Resources | Occupational Health Programs
Pre-Employment/Post-Offer Medical Examinations
Phone: 213-738-2187 | Fax: 213-784-1713

PRE-PLACEMENT
FIREFIGHTER HEALTH HISTORY QUESTIONNAIRE

Applicant instructions:

1. Enter/verify your Applicant Information below.
2. Complete the health questionnaire. The information you provide in this questionnaire is extremely important. It will be used by a physician to advise the County of your ability to perform the essential functions of the position you applied for safely, with or without restrictions. Please fill out the questionnaire completely and accurately.
3. Complete the starred (*) information only on Page 7

Applicant Information. *Please provide the following information:*

Name (last, first, middle initial): ____________________

Gender: ☐ Male ☐ Female

Date of Birth: ____________ Last four Digits of Social Security Number: ____________

Address: ____________________

City: ____________ ZIP: ____________

Home Phone: ____________ Cell Phone: ____________

Job Applied For: ____________________

Health Questionnaire. *Please provide the following information. Do not leave any answers blank; use "N/A" if not applicable, or enter "Don't know":*

1. List your last three hospitalizations (excluding routine childbirth):

Date	Age	Condition	Name of Hospital	City and State

2. List any other operations or surgeries not included in question 1:

Date	Age	Condition	Name of Hospital	City and State

3. Date of last tetanus immunization: ______________________ ☐ Never ☐ Unknown

4. List all medications (prescription and nonprescription) you are currently taking (including vitamins, aspirin, antihistamines, cold medications, reducing aids, recreational drugs, etc.): ______________________

5. List all medications (prescription and nonprescription) not listed above that you have taken in the past two months: ______________________

6. Do you have, or have you ever had, the following (check all that apply)?

- ☐ Vision problems (eye disease, surgeries, temporary/permanent loss of vision)
- ☐ Skin condition (recurrent eczema, irritated skin, open lesions)
- ☐ Dizziness/fainting/loss of consciousness
- ☐ Psychological problems/stress/depression
- ☐ Prior drug/alcohol treatment
- ☐ Asthma/chronic bronchitis/emphysema
- ☐ Bad reaction to cold, heat, heights, or closed spaces
- ☐ Thyroid problems
- ☐ Chest pain or heart problems
- ☐ Fractures (broken bones or ribs)
- ☐ Diabetes
- ☐ Ulcer/irritable bowel/Crohn's disease
- ☐ Cancer, leukemia, or compromised immune system
- ☐ Convulsions/seizures/epilepsy
- ☐ Headaches
- ☐ Chronic fatigue/Gulf War syndrome
- ☐ Tuberculosis
- ☐ Pneumothorax
- ☐ Swollen ankles or varicose veins
- ☐ Bleeding tendency
- ☐ Trouble smelling
- ☐ Hepatitis
- ☐ Hernia
- ☐ Anemia

- ☐ Chronic or recurring pain or limited motion associated with:

  ☐ Neck ☐ Wrist ☐ Back ☐ Ankle ☐ Shoulder ☐ Hand ☐ Hip ☐ Foot ☐ Elbow ☐ Knee

7. Do you currently use tobacco, or have you used it in the past month? ☐ Yes ☐ No

8. Have you ever had a reaction, allergy, and/or sensitivity to any drugs (such as codeine, penicillin, or sulfa), latex, foods, plants, or chemicals? ☐ Yes ☐ No

9. Have you ever had an allergic reaction that affected your breathing? ☐ Yes ☐ No

If "Yes," please describe: ____

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10. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath	☐ Yes	☐ No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ Yes	☐ No
Shortness of breath when walking with other people at an ordinary pace on level ground	☐ Yes	☐ No
Have to stop for breath when walking at your own pace on level ground	☐ Yes	☐ No
Shortness of breath when washing or dressing yourself	☐ Yes	☐ No
Shortness of breath that interferes with your job	☐ Yes	☐ No
Coughing that produces phlegm (thick sputum)	☐ Yes	☐ No
Coughing that wakes you early in the morning	☐ Yes	☐ No
Coughing that occurs mostly when you are lying down	☐ Yes	☐ No
Coughing up blood in the past month	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Wheezing that interferes with your job	☐ Yes	☐ No
Chest pain when you breathe deeply	☐ Yes	☐ No
Any other symptoms that you think may be related to lung problems	☐ Yes	☐ No

If "Yes," please describe: ____

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11. Have you ever had any of the following cardiovascular or heart problems?

High blood pressure	☐ Yes	☐ No
Elevated cholesterol	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Angina	☐ Yes	☐ No

Heart failure ☐ Yes ☐ No

Swelling in your legs or feet (not caused by walking) ☐ Yes ☐ No

Heart arrhythmia (heart beating irregularly) ☐ Yes ☐ No

Heart attack ☐ Yes ☐ No

Any other heart problem that you've been told about ☐ Yes ☐ No

If "Yes," please describe: ____

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12. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest ☐ Yes ☐ No

Pain or tightness in your chest during physical activity ☐ Yes ☐ No

Pain or tightness in your chest that interferes with your job ☐ Yes ☐ No

Heart skipping or missing a beat in the past two years ☐ Yes ☐ No

Heartburn or indigestion that is not related to eating ☐ Yes ☐ No

Any other symptoms that you think may be related to heart or circulation problems ☐ Yes ☐ No

If "Yes," please describe: ____

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13. Have you ever had any of the following problems with a respirator?

Eye irritation ☐ Yes ☐ No

Skin allergies or rashes ☐ Yes ☐ No

Anxiety or claustrophobia ☐ Yes ☐ No

General weakness or fatigue ☐ Yes ☐ No

Any other problem that interferes with your use of a respirator ☐ Yes ☐ No

If "Yes," please describe: ____

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14. Are you currently under medical care for any emotional or physical illnesses? ☐ Yes ☐ No

15. Have you been advised to have any operations that have not yet been done? ☐ Yes ☐ No

16. Have you ever had a physician or healthcare professional give you activity restrictions? ☐ Yes ☐ No

If so, are you back on full duty? ☐ Yes ☐ No

If "No," please describe: ____

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17. Do you take medications at work or before work that you believe could affect your physical or mental function or performance? ☐ Yes ☐ No

18. Have you ever been unable to hold a job or refused employment because of any physical, mental, or other health-related reason? ☐ Yes ☐ No

19. Have you ever been rejected or discharged from a military position because of any physical, mental, or other health-related reason? ☐ Yes ☐ No

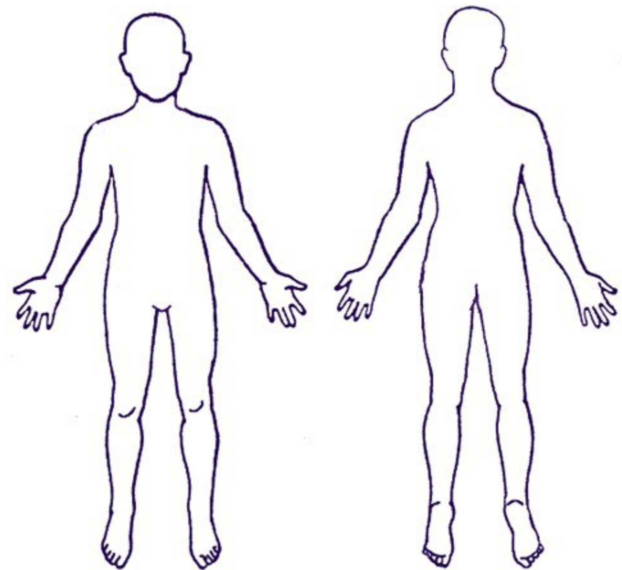
☐ Yes ☐ No

20. Within the past year, have you had repeated feelings of numbness, tingling, or "pins and needles" sensations in one or both hands? ☐ Yes ☐ No

21. Does discomfort in your wrist, arm, or shoulder interfere with your daily activities (eating, writing, sports, etc.) ☐ Yes ☐ No

22. Please mark on the diagrams where you experience any pain, tingling, numbness, or other problems.

xxx xxx	Pain	☐	Tingling or numbness



23. Do you currently have any of the following vision problems?

Wear contact lenses ☐ Yes ☐ No

Wear glasses ☐ Yes ☐ No

Colorblind ☐ Yes ☐ No

Any other eye or vision problem ☐ Yes ☐ No

24. Have you ever had an injury to your ears, including a ruptured eardrum? ☐ Yes ☐ No

25. Do you currently have any of the following hearing problems?

Difficulty hearing	☐ Yes ☐ No
Wear a hearing aid	☐ Yes ☐ No
Any other hearing or ear problem	☐ Yes ☐ No

26. Have you ever or are you currently being treated for any hazardous or toxic exposure (biological, post-exposure, chemical, physical)? ☐ Yes ☐ No

27. Have you had any chemical or biological exposures that you know of and/or have concerns? ☐ Yes ☐ No

28. Relative to this job, is there any health-related condition for which you require accommodation (i.e., job modification or structural changes in work area)? ☐ Yes ☐ No

Applicant Certification: *I hereby certify that all of my statements and answers are true and complete. I understand that any misstatement of material fact may subject me to disqualification or dismissal and may cause forfeiture of all rights to employment.*

Applicant signature:____ Date: ____________

Physician Instructions:

1. Review the questionnaire responses and use this information in conjunction with your physical examination of the applicant to determine the applicant's ability to assume the position sought, with or without the need for work restrictions.
2. Maintain this questionnaire in your files. The County is not to receive this questionnaire.
3. Complete the Healthcare Provider's Findings Report on the next page.
4. Fax ONLY the Healthcare Provider's Findings Report to OHP at (213) 784-1713.

Physician Signature:____ Date: ____________

Physician Comments/Notes: ____

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DO <u>NOT</u> SEND COMPLETED MEDICAL HISTORY QUESTIONNAIRE TO THE COUNTY OF LOS ANGELES

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FIREFIGHTER HEALTHCARE PROVIDER'S FINDINGS REPORT

*Applicant Name: ____

*Job Title: ____

*Email Address: ____________________ *Last Four Digits of SSN: ________ *Phone: __________

*Street Address: ____________________ *City, State: ______________ *Zip: __________

Department Number: ____________________ Item Number: ____________________

Date of Birth: ____________________ Date of Evaluation: ____________________

Applicant seen at: ☐ Westchester ☐ Glendale ☐ Irwindale

The above-named applicant was evaluated in our clinic, and the following additional information was used to determine if this applicant is able to assume this position, from a physical medical perspective, with or without work restrictions (check all that apply):

- ☐ Applicant-completed Health History Questionnaire dated ____________________
- ☐ Respirator Questionnaire dated ____________________
- ☐ Essential Functions Job Analysis
- ☐ Job Description
- ☐ Other: ____________________

Physician's determination (please initial your choice):

_________ The applicant has no work restrictions. The applicant is able to perform the essential functions of the position.

_________ I am unable to make a determination due to the following (do not list any private or protected medical information, including diagnosis, condition or treatment information):

____

____

_________ The applicant was issued the following work restrictions:

____

____

The work restrictions are: ☐ Permanent ☐ Temporary through ______________(date)

Physician's Name: ____

Physician's Signature: ______________________________ Date: __________

RETURN ONLY THIS PAGE TO OHP VIA FAX AT (213) 784-1713