**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
# HEALTH HISTORY QUESTIONNAIRE

**Applicant Instructions:**

1. Enter/verify your personal information below.

2. Complete the Health History Questionnaire. The information you provide in this questionnaire is extremely important. It will be used by a physician or other healthcare professional to advise the County of your ability to perform the essential functions of the job safely, with or without restrictions. Please fill out the questionnaire completely and accurately. Do not leave any answers blank; use "N/A" if not applicable, or enter "Don't know."

3. Complete the starred (*) information only on Page 5.

***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: _____

Department: _____

Job Applied For: _____

***Health Survey:*** *Answer all of the following questions. As you answer the questionnaire, be as accurate as possible, and do not leave any answers blank.*

1. Are you presently taking any medications (prescription or non-prescription) that affect your balance, awareness, hearing, sight, or ability to walk, stand, sit, lift, bend, or reach? ☐Yes ☐No

   If your answer is "Yes," then provide the following information:

   Type of medication: _____

   Specific work limitation(s): _____

   _____

2. Have you undergone any operations, surgeries or hospitalizations that limit your current ability to perform the essential physical or mental functions of the position for which you are being considered? ☐Yes ☐No

   If your answer is "Yes," then provide the following information:

   Date of procedure/hospitalization: _____

   Specific work limitation(s): _____

   _____

3. Has a physician restricted you from performing any physical or mental activities that are necessary to perform the essential job functions of the position for which you are being considered? ☐Yes ☐No

| Date Restriction Issued | Name of Physician | Restriction |
|---|---|---|
| | | |
| | | |
| | | |

4. In your opinion, do you need a work-related accommodation for any mental or physical condition that limits your current ability to perform the essential functions of the job for which you are being considered? Such mental of physical conditions may include, but are not limited to: vision or hearing impairments, allergies, skin conditions, dizziness, fainting, loss of consciousness, working in elevated locations, convulsions, seizures, epilepsy, breathing problems, diabetes, headaches, and psychological or emotional disorders. ☐Yes ☐No

   If your answer is "Yes," then provide the specific work limitation(s) for the condition you seek a work-related accommodation for: _____

   _____

   _____

5. Do you experience any chronic pain or musculoskeletal problems that limit your ability to perform the essential functions of the job for which you are being considered? These problems may include but are not limited to pain; tingling; numbness; limited motion; and limitations in walking, standing, sitting, bending, lifting, and reaching. ☐Yes ☐No

   If your answer is "Yes," then check or describe the body part(s) affected:

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

   ☐ Other _____

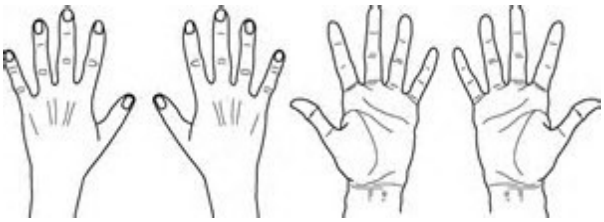
   Please indicate any limitation(s) created by your condition: _____

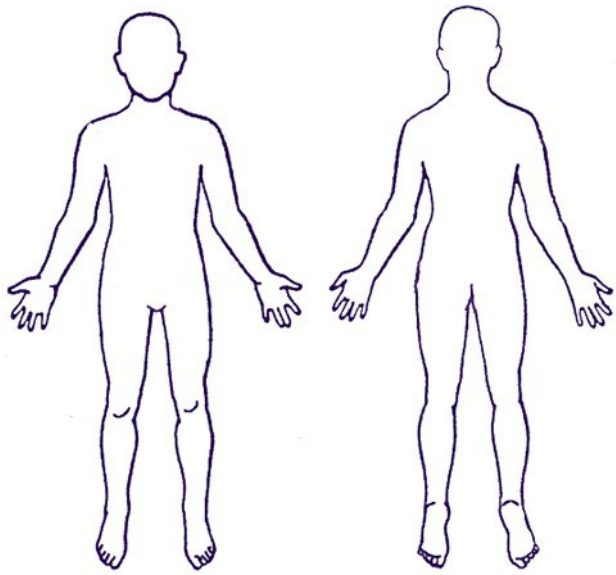
   _____

   _____

6. Please mark on the diagrams where you experience any pain, tingling, numbness or other problems identified in response to question 5.

   xxx xxx Pain  ▯▯▯ ▯▯▯ Tingling or numbness





***Potentially Hazardous Environment:*** *Answer the following questions only if the job you applied for requires that you work in an environment where you are likely to come into contact with chemicals or substances (e.g., latex, radiation, lead, paints, glues, dust); or use personal protective gear or equipment. If neither of these requirements applies to the job, then check "N/A" and proceed to the Applicant Certification section.*

7. Do you have an allergy and/or sensitivity (e.g., irritation to eyes or skin, difficulty breathing) to latex, chemicals, or other environmental substances that limits your current ability to perform the essential duties/functions of the job for which you are being considered? ☐Yes ☐ No ☐ N/A

   If your answer is "Yes," then provide the following information:

   Chemical(s) or substance(s) sensitive to: _____

   Specific work limitation(s): _____

8. Have you ever worked with any of the following? (Check all that apply.)

☐Asbestos ☐ Dust ☐ Latex ☐ Lead ☐ Noise ☐ Pesticides ☐ Radiation

☐ Silica powder ☐ Solvents ☐ Substances that irritated your skin or eyes

☐ Substances that caused you breathing difficulties ☐ N/A

***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 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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# 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 evaluate if this applicant is able to perform the essential functions of the position, from a medical perspective (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**