

CONFIDENTIAL

**CRANE OPERATOR  
MEDICAL HISTORY QUESTIONNAIRE**

**COUNTY OF LOS ANGELES**

**At the time of your medical appointment, 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):	EMPLOYEE NUMBER	BIRTHDAY	AGE
ADDRESS:	CITY:	STATE, ZIP CODE	
PRESENT POSITION:	HOME/CELL PHONE (     )	WORK PHONE (     )	

**Have you have had any of the following conditions in the last 5 years?**

YES	NOT SURE	NO		YES	NOT SURE	NO	
___	___	___	1. Elevated Liver Enzymes	___	___	___	18. Angina
___	___	___	2. Pancreatitis	___	___	___	19. Heart Failure
___	___	___	3. Chronic Neurological Disease	___	___	___	20. Loss of Consciousness
___	___	___	4. Tremors	___	___	___	21. Seizure
___	___	___	5. Loss of Coordination	___	___	___	22. Fainting Spells
___	___	___	6. Transient Ischemic Attack	___	___	___	23. Recurrent Dizziness
___	___	___	7. ADHD	___	___	___	24. Thyroid Trouble
___	___	___	8. Suicide Attempt	___	___	___	25. Sleep Apnea
___	___	___	9. Psychiatric Hospitalization	___	___	___	26. Drug/Alcohol Treatment
___	___	___	10. Manic Episode	___	___	___	27. Muscular Disease
___	___	___	11. Panic Attack	___	___	___	28. Asthma or Lung Disease
___	___	___	12. Low Blood Sugar	___	___	___	29. Kidney Disease
___	___	___	13. Head/brain injury or disorder	___	___	___	30. Liver Disease
___	___	___	14. Heart Disease or Surgery	___	___	___	31. Diabetes
___	___	___	15. High Blood Pressure	___	___	___	32. Stroke or Paralysis
___	___	___	17. Positive Cardiac Stress Test	___	___	___	33. Spinal Injury or Disease

**Do you currently have or have you recently had any of the following?**

YES	NOT SURE	NO		YES	NOT SURE	NO	
___	___	___	34. Difficulty with Night Vision	___	___	___	43. Irregular Heartbeat
___	___	___	35. Change in Vision	___	___	___	44. Chest Pain
___	___	___	36. Blurred or Double Vision	___	___	___	45. Daytime Sleepiness
___	___	___	37. Blind Spot	___	___	___	46. Snoring
___	___	___	38. Impaired Peripheral Vision	___	___	___	47. Pauses in Breathing while Asleep
___	___	___	39. Hernia	___	___	___	48. Shortness of Breath
___	___	___	40. Headaches	___	___	___	49. Low Back Pain
___	___	___	41. Inability to Focus	___	___	___	50. Missing or impaired hand, arm, foot, leg, toe
___	___	___	42. Difficulty Concentrating	___	___	___	

