Name _____ MRNO _____

[GMHQ] GENERAL MEDICAL HISTORY QUESTIONNAIRE

LOS ANGELES DEPARTMENT OF WATER AND POWER - OCCUPATIONAL HEALTH SERVICES
111 North Hope Street Rm. 538, Los Angeles, CA 90012 Telephone (213) 367-2001

Name (Last, First, MI)				
Birthdate	**Age**	**Gender**	**Ethnicity**	**Social Security Number**
Home Telephone Number			**Work Telephone Number**	
Home Address (Street)				**Apt. No.**
City			**State**	**Zip Code**

Date	Employee Number
Class Code	**Payroll No.**
Class Title	

Have you ever (If "yes", explain in "9. Comments"):

1. Previously worked for the Los Angeles Department of Water and Power?
   ☐ Yes ☐ No
   1a. If "yes" where and when? _____
2. Worked for the city before?
   ☐ Yes ☐ No
3. Had a medical exam for any Los Angeles City job?
   ☐ Yes ☐ No
4. Received, have pending , or intend to apply for pension, or compensation for existing or past disability?
   ☐ Yes ☐ No
5. Filed for Worker's Compensation because of any illness or injury received on or off the job?
   ☐ Yes ☐ No

Do you have:

6. Any limitation to the full use of any part of your body?
   ☐ Yes ☐ No
7. Any physical defects?
   ☐ Yes ☐ No
8. Any artificial apparatus that you must wear (hearing-aids, pacemaker, etc.)?
   ☐ Yes ☐ No
9. Comments: _____

Personal History (check box if you are allergic to any of the following):

☐ Penicillin ☐ Aspirin ☐ Pollen/Dust ☐ Sulfa ☐ Iodine ☐ Foods (list in comments)
☐ Other antibiotics (explain in comments) ☐ Chemicals (list in comments) ☐ Others (list in comments)

Comments _____

Name _____ MRNO _____

PERSONAL HISTORY: Check if you have ever had or now have (explain all yes responses in blanks at end of each section)

1.		NOSE/THROAT
Yes	No	
		Nose bleed (frequent)
		Sinus trouble
		Colds (frequent)
		Hoarseness (frequent)
		Perforated septum
		Hay fever
		Other nose and/or throat problems

2.		EYES
Yes	No	
		Eye injury which affected vision
		Need to wear corrective lenses
		Cataract(s)
		Eyes frequently red (conjunctivitis)
		Eye Disease (glaucoma, etc.)
		Color blindness
		Blurred vision
		Any other eye problems

3.		LIVER
Yes	No	
		Gallbladder trouble
		Jaundice
		Hepatitis
		Cirrhosis
		Enlarged or tender liver
		Enlarged or tender spleen

4.		MUSCULOSKELETAL
Yes	No	
		Joint injury
		Low back trouble or strain
		Amputation
		Arthritis
		Sciatica
		Neck injury
		Foot trouble
		Bursitis
		Tendonitis
		Gout
		Bone infection (osteomyeltitis)
		Fracture
		Other bone or muscle problems

5.		CARDIOVASCULAR
Yes	No	
		Heart trouble
		High blood pressure
		Palpitation
		Murmur angina
		Heart attack
		Rheumatic fever
		Swelling of ankles
		Leg pain when walking
		Numbness of feet
		Varicose veins
		Leg or foot ulcers

6.		CANCER
Yes	No	
		Have you ever had CANCER?
		Was it treated?
		How? Surgery?
		Radiation or Cobalt?
		Chemotherapy?
		What kind of Cancer:
		(lung, stomach, breast, etc.)

7.		SKIN
Yes	No	
		Psoriasis
		Eczema
		Hives or breaking out
		Acne infection
		Skin cancer
		Other skin problems

8.		BLOOD
Yes	No	
		Abnormal bleeding
		Anemia
		Bruising easily
		Phlebitis
		Sickle cell disease
		Leukemia
		Clotting problems
		Other problems with blood

9.		UROLOGY
Yes	No	
		Kidney trouble or stone(s)
		Bladder trouble or stone(s)
		Difficulty in urinating (pain, etc.)
		Blood in the urine
		Prostate trouble
		Urinary tract infection
		Hernia (rupture)

10.		NEUROPSYCHIATRIC
Yes	No	
		Nervous breakdown/exhaustion
		Need for mental care
		Mental hospitalization
		Trouble sleeping
		Depression/excessive worry
		Attempted suicide
		Epilepsy/convulsions
		Fainting spells
		Head injury
		Concussion
		Stroke
		Loss of consciousness
		Severe or chronic headache(s)
		Paralysis (weakness)
		Numbness/tingling
		Palsy or tremors
		Severe or frequent dizziness
		Other neuropsychiatric problems

11.		PULMONARY
Yes	No	
		Asthma (age of last episode)
		Breathing difficulty
		Coughing up blood
		Cough (persistent)
		Chest X-ray which was abnormal
		Tuberculosis
		Emphysema
		Pneumonia
		Asbestosis
		Other lung problems

12.		GASTROINTESTINAL
Yes	No	
		Nausea or vomiting (frequent)
		Diarrhea (frequent)
		Hiatal hernia
		Ulcer
		Dark tarry stools
		Colitis
		Hemorrhoids
		Rectal problems
		Other stomach/digestive conditions

13.		GLANDS
Yes	No	
		Diabetes (sugar in the urine)
		Thyroid trouble
		Pancreatitis
		Other problems with glands

14.		GENERAL
Yes	No	
		Measles
		Mumps
		Chickenpox
		Rubella
		Other childhood diseases
		Mononucleosis
		Meningitis
		Other infectious diseases
		Alcoholism
		Drug addiction
		Other drug or alcohol related problems

15.		HEARING
Yes	No	
		In hearing conservation program
		Ear problems
		Injury to head or ear(s)

Name _____ MRNO _____

List All Hospitalizations

Reason Hospitalized:	
Date of Admission:	
Name of Hospital:	
Name of Physician:	
Reason Hospitalized:	
Date of Admission:	
Name of Hospital:	
Name of Physician:	

Personal Habits

1. Do you exercise regularly? ☐ Yes ☐ No If Yes, please state:
   Form of exercise? _____ How Long? _____ Number of sessions per week? _____

2. Have you ever used any form of tobacco? ☐ Yes ☐ No If Yes, answer "A" through "C":
   A. At what age did you begin using tobacco?
      Cigarettes ☐ age Cigars ☐ age Pipe ☐ age Chewing Tobacco ☐ age
   B. How much do you use per day or if you have stopped how much did you use per day:
      Cigarettes ☐ pkgs. Cigars ☐ Pipe ☐ bowls Chewing Tobacco ☐ ounces
   C. If you have stopped, then how many years did you use:
      Cigarettes ☐ years Cigars ☐ years Pipe ☐ years Chewing Tobacco ☐ years

3. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, answer the following:
   A. Estimated average weekly consumptions is:

Beer	☐ Occasionally	☐ 1-2 cans	☐ 3-4 cans	☐ 5 or more
Wine	☐ Occasionally	☐ 1-2 glasses	☐ 3-4 glasses	☐ 5 or more
Hard Liquor	☐ Occasionally	☐ 1-2 drinks	☐ 3-4 drinks	☐ 5 or more

   Comments: _____

4. Do you drink caffeinated beverages?

Coffee	☐ Yes	☐ No	If yes, estimated cups per day	☐
Tea	☐ Yes	☐ No	If yes, estimated cups per day	☐
Caffeinated soft drinks	☐ Yes	☐ No	If yes, estimated bottles/cans per day	☐

5. Do you regularly take drugs or medications of any type? ☐ Yes ☐ No If Yes, answer "A" and "B":

   A. Prescribed medicines (i.e., heart medication, birth control pills, high blood pressure pills)

Medicine	_____	Dosage	_____	Purpose	_____
Medicine	_____	Dosage	_____	Purpose	_____
Medicine	_____	Dosage	_____	Purpose	_____
Medicine	_____	Dosage	_____	Purpose	_____

   B. Non-prescription pills, capsules, liquids, or vitamins:

Name	_____	Dosage	_____	Purpose	_____
Name	_____	Dosage	_____	Purpose	_____
Name	_____	Dosage	_____	Purpose	_____
Name	_____	Dosage	_____	Purpose	_____

Name _____ MRNO _____

History of Occupational Exposures:		
Yes	No	Have you ever been exposed to:
		Substances which irritated your skin or eyes
		Sprays or powders for insects or plants
		Prolonged X-rays or other radiation
		Dusty conditions
		Smokey conditions
		Strong fumes
		Strong vapors

Yes	No	Have you ever
		Been off work because of back problems
		Hurt your back in sports activities
		Seen a doctor for back pain or problems
		Had back discomfort lifting 25-30 pounds
Yes	No	Have you had a bad reaction to:
		High environmental temperatures
		Low environmental temperatures

Yes	No	Have you ever received medical treatment for exposure to a chemical or physical agent? (List substances and dates)

Yes	No	Do you have any health problems which are/or were caused by substances with which you worked?

List number of years exposed to loud noises:

	Military duty
	Hobbies
	Power tools

How many days have you missed from work due to illness in the past 12 months? ____

Date of last tetanus booster: ____ mm/dd/yyyy

List all hobbies you have had or now have:

Type of Hobby	Years	Average hours devoted to hobby per week?
1		
2		
3		
4		
5		

With what toxic/hazardous materials have you worked?

Name of Material	Years	Hours exposed per week?
1		
2		
3		
4		
5		

Have you ever worn a respirator? ☐ Yes ☐ No What type of respirator? ____

How many hours per week? ____ Why did you wear a respirator? ☐ Dust ☐ Fumes ☐ Vapor

Present health status: Please state the condition of your present health: ____

Personal physician or health care provider:

Name			
Address (Street)			
City, State, Zip		Telephone	

I hereby authorize the Los Angeles Department of Water & Power to perform a complete medical examination and laboratory tests. I certify that I have reviewed the above information supplied by me and that it is true and correct to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned to furnish the LADWP's Occupational Health Services Section, a complete transcript of my medical records for the purpose of processing my application for employment. I understand that any omission or falsification of any medical information may disqualify me. The LADWP is an Equal Opportunity/Affirmative Action Employer.

Applicant Signature	Applicant Name (Print)	Date
Reviewer Comments:		
Reviewer Signature	Reviewer Name (Print)	Date Reviewed