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)						Date		Employee Number
Birthdate	Age	Gender	Ethnicity	Social Security Nu	mber	Class Code		Payroll No.
Home Telephone Numb	er		Work Telephon	e Number		Class Title		
Home Address (Street)				Apt. No.				
City			State	Zip Code				
II acu	,,	1: : !!0 /	-					
Have you ever (If " <u>ye</u>	-		,					
1. Previously worked		_	les Departmen	t of Water and P	ower?			
☐ Yes								
1a. If "yes" where								
2. Worked for the city Yes	y befor							
3. Had a medical exar	n for a	any Los Ang	geles City job?					
□ Yes			- • •					
4. Received, have pen	ding,	or intend to	o apply for per	nsion, or compen	sation for existin	ng or past dis	ability?	
□ Yes			11 / 1	. 1			·	
5. Filed for Worker's	Comp	ensation be	cause of any il	lness or injury re	ceived on or off	the job?		
□ Yes		No						
Do you have:								
6. Any limitation to the	ne full	use of any	part of your bo	ody?				
□ Yes		No						
7. Any physical defect	ts?							
□ Yes		No						
8. Any artificial appar			t wear (hearing	g-aids, pacemake	;, etc.)?			
□ Yes		No						
9. Comments:								
		•••		0.1.0.1				
Personal History (cl	heck b	oox if you a	are allergic to	any of the follo	wing):			
☐ Penicillin ☐	Aspir	rin 🗖	Pollen/Dust	☐ Sulfa			☐ Foods (list	t in comments)
☐ Other antibiotic	s (exp	lain in com	ments)	☐ Che	micals (list in co	mments)	☐ Others (lis	et in comments)
Comments								

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	<u> </u>
		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	MUSCULUSKELETAL
1 68	110	Joint injury
		Low back trouble or strain
		Amputation
		Arthritis
		Arthritis Sciatica
		Arthritis Sciatica Neck injury
		Arthritis Sciatica
		Arthritis Sciatica Neck injury Foot trouble
		Arthritis Sciatica Neck injury Foot trouble Bursitis
		Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis
		Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture
		Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyelitis)
		Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture
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		Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems
5.	N	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture
5. Yes	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure Palpitation
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure Palpitation Murmur angina
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyelitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure Palpitation Murmur angina Heart attack
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyelitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure Palpitation Murmur angina Heart attack Rheumatic fever
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure Palpitation Murmur angina Heart attack Rheumatic fever Swelling of ankles
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure Palpitation Murmur angina Heart attack Rheumatic fever Swelling of ankles Leg pain when walking
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure Palpitation Murmur angina Heart attack Rheumatic fever Swelling of ankles Leg pain when walking Numbness of feet
	No	Arthritis Sciatica Neck injury Foot trouble Bursitis Tendonitis Gout Bone infection (osteomyeltitis) Fracture Other bone or muscle problems CARDIOVASCULAR Heart trouble High blood pressure Palpitation Murmur angina Heart attack Rheumatic fever Swelling of ankles Leg pain when walking Numbness of feet Varicose veins
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6.		CANCER
Yes	No	
103	110	Have you ever had CANCER?
		Was it treated?
		How? Surgery?
		Radiation or Cobalt?
		Chemotherapy?
		What kind of Cancer:
		(lung, stomach, breast, etc.)
		(iding, stormach, breast, etc.)
7.		SKIN
Yes	No	
		Psoriasis
		Eczema
		Hives or breaking out
		Acne infection
		Skin cancer
		Other skin problems
\neg		'
-		
		
		DI OOD
8.		BLOOD
Yes	No	
		Abnormal bleeding
		Anemia
		Bruising easily
		Phlebitis
		Sickle cell disease
		Leukemia
		Clotting problems
		Other problems with blood
		LIBOLOGY
9.	3.7	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
		e many emer many
		Hernia (rupture)
		Hernia (rupture)
1 0. Yes	No	Hernia (rupture) NEUROPSYCHIATRIC
	No	Hernia (rupture)
	No	NEUROPSYCHIATRIC Nervous breakdown/exhaustion
	No	NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care
	No	NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization
	No	NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping
	No	NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping Depression/excessive worry
	No	NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping Depression/excessive worry Attempted suicide
	No	NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping Depression/excessive worry
	No	NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping Depression/excessive worry Attempted suicide Epilepsy/convulsions
	No	Hernia (rupture) NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping Depression/excessive worry Attempted suicide Epilepsy/convulsions Fainting spells
	No	Hernia (rupture) NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping Depression/excessive worry Attempted suicide Epilepsy/convulsions Fainting spells Head injury
	No	Hernia (rupture) NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping Depression/excessive worry Attempted suicide Epilepsy/convulsions Fainting spells Head injury Concussion
	No	Hernia (rupture) NEUROPSYCHIATRIC Nervous breakdown/exhaustion Need for mental care Mental hospitalization Trouble sleeping Depression/excessive worry Attempted suicide Epilepsy/convulsions Fainting spells Head injury Concussion Stroke
	No	Hernia (rupture) NEUROPSYCHIATRIC 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
	No	Hernia (rupture) NEUROPSYCHIATRIC 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
	No	NEUROPSYCHIATRIC 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)
Yes	No	NEUROPSYCHIATRIC 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)
	No	NEUROPSYCHIATRIC 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
	No	NEUROPSYCHIATRIC 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
	No	NEUROPSYCHIATRIC 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
	No	NEUROPSYCHIATRIC 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
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11.		PULMONARY
Yes	No	
100	110	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
IJ.		
	No	GERTIDS
Yes	No	
	No	Diabetes (sugar in the urine)
	No	Diabetes (sugar in the urine) Thyroid trouble
	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis
	No	Diabetes (sugar in the urine) Thyroid trouble
	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis
	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis
Yes	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis
Yes	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis
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Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism
Yes 14.		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism Drug addiction Other drug or alcohol related
Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism
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14. Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism Drug addiction Other drug or alcohol related problems
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14. Yes		Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism Drug addiction Other drug or alcohol related problems
Yes	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism Drug addiction Other drug or alcohol related problems HEARING
Yes	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism Drug addiction Other drug or alcohol related problems HEARING In hearing conservation program
Yes	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism Drug addiction Other drug or alcohol related problems HEARING In hearing conservation program Ear problems
Yes	No	Diabetes (sugar in the urine) Thyroid trouble Pancreatitis Other problems with glands GENERAL Measles Mumps Chickenpox Rubella Other childhood diseases Mononucleosis Meningitis Other infectious diseases Alcoholism Drug addiction Other drug or alcohol related problems HEARING In hearing conservation program

Name			
rvanic			

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? □ Y Form of exercise?	Yes □ No If Yes, please state: How Long? Number of sessions per week?
B. How much do you use per day or if you have stop Cigarettes pkgs. Cigars C. If you have stopped, then how many years did you	age Pipe age Chewing Tobacco age pped how much did you use per day: Pipe bowls Chewing Tobacco ounces
3. Do you drink alcoholic beverages?	No If yes, answer the following: □ 1-2 cans □ 3-4 cans □ 5 or more □ 1-2 glasses □ 3-4 glasses □ 5 or more □ 1-2 drinks □ 3-4 drinks □ 5 or more
4. Do you drink caffeinated beverages? Coffee □ Yes □ No Tea □ Yes □ No	If yes, estimated cups per day If yes, estimated cups per day
Caffeinated soft drink: 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 Medicine Medicine Medicine Medicine	Dosage Purpose Dosage Purpose Dosage Purpose Dosage Purpose Dosage Purpose Dosage Purpose
B. Non-prescription pills, capsules, liquids, or vitamins: Name Name Name	Dosage Purpose Dosage Purpose Dosage Purpose
Name	Dosage Purpose

List all hobbies you have had or now have: With what toxic/hazardous materials have you w Average hours devoted											
Substances which initiated your skin or eyes Sprays or powders for insects or plants Prolonged X-rays or powders for insects or plants Prolonged X-rays or other radiation Dusty conditions Smokey conditions Strong fumes Hald back discomfort lifting 25-30 powders Strong fumes Hald back discomfort lifting 25-30 powders Strong vapors Wes No Have you had a bact reaction to: High environmental temperatures Low environmental temperatures	Histo	ry of Occupational E	xposures:								
Sprays or powders for insects or plants Prolonged X-rays or other radiation Dusty conditions Smokey conditions Smokey conditions Smokey conditions Strong fumes Strong fumes Strong fumes I Had bask discomfort lifting 25-30 point Yes No Have you had a bad reaction to: High environmental temperatures I Low	Yes N					Yes	No				
Perlonged X-rays or other adiation Dusty conditions Smokey conditions Strong finnes Had back disconfort lifting 25-30 por Yes No Have you had a bad reaction to: Had back disconfort lifting 25-30 por Yes No Have you ever received medical ireatment for exposure to Low environmental temperatures Low environmental temperatures Ves No Have you ever received medical ireatment for exposure to a chemical or physical agent? (List substances and dates) Low environmental temperatures Ves No Do you have any health problems which emused by substances with which you we Hobbies Power tools Date of last tetanus booster: How many days have you missed from work due to illness in the past 12 months? Date of last tetanus booster: mm/ Date of last tetanus booster: mm/ Strange from the past of last tetanus booster: mm/ Name of Material Years 1		Substances which irr	itated your	skin or eyes				Been off work becau	ise of back pro	blems	
Busty conditions Smokey conditions Smokey conditions Smokey conditions Smokey conditions Strong fumes Strong fumes Strong fumes Strong fumes Strong fumes Strong wapors		Sprays or powders for	or insects or	plants				Hurt your back in sp	orts activities		
Smokey conditions Strong firmes Strong firmes Strong firmes Strong firmes High environmental temperatures Low environm		Prolonged X-rays or	other radiat	tion				Seen a doctor for ba	ck pain or pro	blems	
Strong tyapors High environmental temperatures Low environme		Dusty conditions						Had back discomfor	t lifting 25-30	pounds	
Strong vapors		Smokey conditions				Yes	No	Have you had a bad			
Yes No		Strong fumes						High environmental	temperatures		
List number of years exposed to loud noises: Military duty		Strong vapors						Low environmental	temperatures		
List number of years exposed to loud noises: Military duty							1				
List number of years exposed to loud noises: Military duy	Yes N			_		Yes	No	- -	-		
Military duty		a chemical or physical a	gent? (List sub	ostances and dates	s)			caused by substances	with which you	ı worke	<u>4</u> ?
Military duty How many days have you missed from work due to illness in the past 12 months?											
Military duty	List nu	mber of years exposed to	o loud noise	s:							
Hobbies Power tools Date of last tetanus booster:		1 .				Hov	v man	y days have you misse	ed from work		
Power tools Date of last tetanus booster:		, , ,									
List all hobbies you have had or now have: Average hours devoted Name of Material Years 1 2 3 3 4 4 5 5 5 5 5 Have you ever worn a respirator? Yes No What type of respirator? Dust Furnes Furnes Present health status: Please state the condition of your present health: Personal physician or health care provider: Name Address (Street) Cdty, State, Zap Telephone Telephon						uuc	ш	ess in the past 12 mor	111115:		
List all hobbies you have had or now have: Average hours devoted Name of Material Years Pears		Power tools				Б.	6.1				
List all hobbies you have had or now have: Average hours devoted Name of Material Years Parts						Date	e of la	st tetanus booster:			
Type of Hobby Years to hobby per week? 1									n	nm/dd/y	уууу
Type of Hobby Years to hobby per week? 1	T 11	1 11: 1 1 1	1			3377* . 1	,	/1 1		,	15
Type of Hobby Years to hobby per week? Name of Material Years 1 2 2 3 3 4 4 5 5 5 5 5 5 5 5	List all	hobbies you have had or	now have:	T		With	n wha	t toxic/hazardous mat	terials have you		
1 2 3 3 4 4 5 5 5 5 1 1 1 2 2 3 3 3 4 4 5 5 5 5 1 1 1 2 2 1 1 2 2 3 3 3 4 4 5 5 5 5 5 1 1 1 2 2 1 1 2 2 1 1 2 2 1 1 2 2 3 3 3 4 4 5 5 5 5 1 1 1 2 2 1 1 2 1 2 1 2 1 1 2 1 2 1 1 2 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1				Average hours of	devoted					Hour	s expose
2 3 4 4 5 3 4 4 5 5 4 4 5 5 4 4 5 5 4 4 5 5 5 6 4 5 5 6 6 6 6		Type of Hobby	Years	to hobby per we	eek?		Nan	ne of Material	Years	per w	eek?
3	1					1					
3 4 4 5 5 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5	2					2					
4						2					
Have you ever worn a respirator?										+	
Have you ever worn a respirator?											
How many hours per week? Why did you wear a respirator? Dust Fumes Present health status: Please state the condition of your present health: Personal physician or health care provider: Name Address (Street) City, State, Zip 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 abov 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 Occupal 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 medical information may disqualify me. The LADWP is an Equal Opportunity/Affirmative Action Employer. Applicant Signature Applicant Name (Print) Date Reviewer Comments:	5					5					
How many hours per week? Why did you wear a respirator? Dust Fumes Present health status: Please state the condition of your present health: Personal physician or health care provider: Name Address (Street) City, State, Zip 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 abov 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 Occupal 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 medical information may disqualify me. The LADWP is an Equal Opportunity/Affirmative Action Employer. Applicant Signature Applicant Name (Print) Date Reviewer Comments:											
Present health status: Please state the condition of your present health: Personal physician or health care provider: Name Address (Street) City, State, Zip 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 abov 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 Occupal 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 medical information may disqualify me. The LADWP is an Equal Opportunity/Affirmative Action Employer. Applicant Signature Applicant Name (Print) Date Reviewer Comments:	Have y	ou ever worn a respirato:	r? 🔲	Yes \square No	o What typ	pe of re	spirat	or?			
Personal physician or health care provider: Name Address (Street) City, State, Zip I 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 abov 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 Occupated 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 medical information may disqualify me. The LADWP is an Equal Opportunity/Affirmative Action Employer. Applicant Signature Applicant Name (Print) Date Reviewer Comments:	How n	nany hours per week?			Why did you v	wear a r	espira	tor? Dust	☐ Fumes		Vapor
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