County of Alameda
Health History Questionnaire

INSTRUCTIONS

Agency/Department Representative Instructions:

1. Complete the Agency/Department information at the top of page 1.
2. Enter the candidate's name on the form and give it to the candidate with these instructions to complete the five-page questionnaire.

Candidate Instructions:

1. Enter/verify your personal information in the candidate information section.
2. Complete the five-page Health History Questionnaire.

- If this is for a sedentary position, please complete and submit this questionnaire to the Alameda Health System-Employee Health Services (AHS-EHS) by the due date, via fax, mail, or in person to:

  AHS-EHS
  15400 Foothill Blvd., Building "C", 1st Floor, Room #130
  San Leandro, CA 94578
  Phone: 510-346-7551 / Fax: 510-346-7579

- If faxed or mailed, the candidate should call AHS-EHS to confirm receipt of the document.

- If this is for a non-sedentary position, please complete this questionnaire and bring it to the selected medical clinic on your medical appointment date along **with a picture ID**.

The information you provide in this questionnaire is extremely important. It will be used by a physician or health care professional to advise the County of your ability to perform the essential functions of the job safely without endangering yourself or others.

Please fill out the attached five-page *Health History Questionnaire* completely and accurately. **Do not leave any answers blank; use "N/A" if not applicable or "Don't know"**.

Clinician Instructions:

1. Please review this questionnaire.
2. If this is for a sedentary position, please fax a medical clearance to the Agency/Department representative or fax a request for a physical exam and/or tests.
3. If this is for a non-sedentary position, use this in conjunction with your physical examination of the employee. Fax the results to the Agency/Department representative on your medical clearance form.
4. Please retain this questionnaire in your file.

County of Alameda
Health History Questionnaire

Agency/Department information: *To be completed by the Agency/Department representative.*

Department: _____ Unit: _____

Job Classification: _____ ☐ Sedentary ☐ Non-Sedentary

Agency/Department Representative:

_____

Name Email Phone# Fax#

For sedentary positions, the candidate must submit the completed questionnaire to the medical provider by: _____ (due date).

Candidate information: *The candidate completes/verifies this information and answers the rest of the questionnaire*

Name: _____ Sex: ☐ Male ☐ Female Date of Birth: _____

Address: _____City: _____ Zip: _____

Home Phone: _____ Social Security #: XXX-XX-_____
(Last 4 digits)

The information you provide in this questionnaire is extremely important. It will be used by a physician or health care professional to advise the County of your ability to perform the essential functions of the job safely without endangering yourself or others.

Please fill out the following five-page *Health History Questionnaire* completely and accurately. **Do not leave any answers blank; use "N/A" if not applicable or "Don't know"**.

Health History Questionnaire

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

   If your answer is "Yes", provide the following information below:
   a. Type of medication _____
   b. Specific work limitation(s) _____
   _____
   c. Type of job accommodation(s) requested (if any) _____
   _____

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

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

a. Date of procedure/hospitalization _____

b. Specific work limitation(s) _____

_____

c. Type of job accommodation(s) requested (if any) _____

_____

3. Has a physician restricted you from currently performing any physical or mental activities that are necessary to perform your essential job duties/functions? Yes ☐ No ☐.

Date Restriction Given	Name of Physician	Restriction

_____

_____

4. Do you require any work-related accommodation for a mental or physical condition(s) that limits your current ability to perform the essential mental or physical duties/functions of your job? These may include, but not limited to the following: vision or hearing impairment, allergies, skin condition, dizziness/fainting/loss of consciousness, working in elevated locations, convulsions/seizures/epilepsy, breathing problems, diabetes, headaches, musculoskeletal programs, psychological or emotional disorders, drug/alcohol treatment. Yes ☐ No ☐.

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

a. Specific work limitation(s) _____

_____

b. Type of job accommodation(s) requested (if any) _____

_____

5. Do you currently experience any chronic pain or musculoskeletal problems which limit your ability to perform the essential duties/functions of your job? These may include, but not limit to the following: pain; tingling; numbness; limited motion; limitation in walking, standing, sitting, bending, lifting, and reaching. Yes ☐ No ☐.

If your answer is "Yes", circle below the body part(s) affected:

Neck	Shoulder	Ankle	Wrist	Hand	Other _____
Back	Hip	Knee	Elbow	Foot	

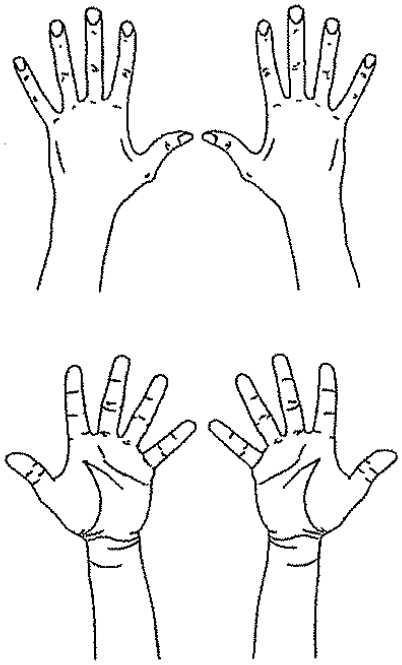
Please indicate any limitation(s) created by your condition:

_____

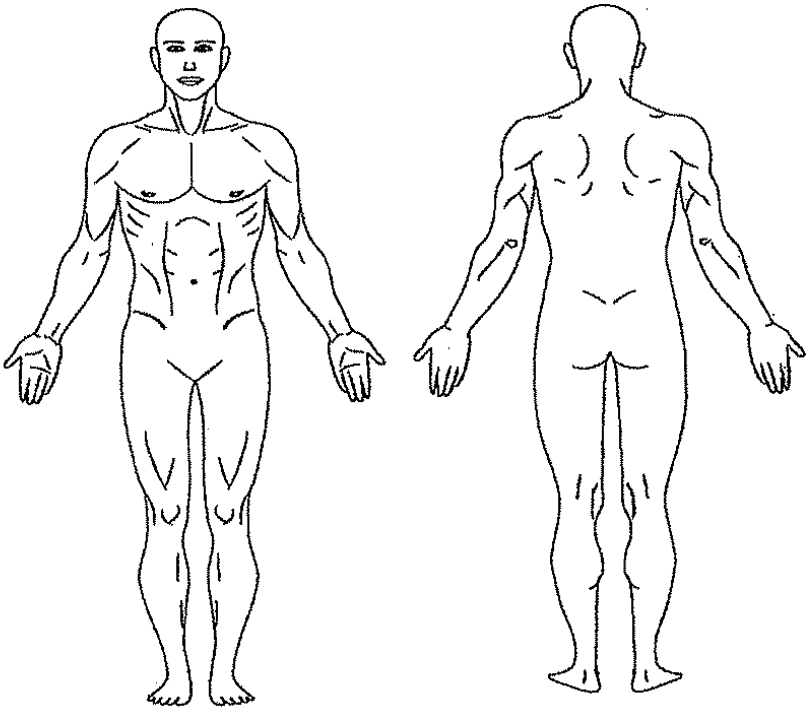
_____

6. Please mark on the diagrams below where you're currently experience pain, tingling, numbness or other problems identified in response to Question #5.

Pain = "xxxx"



Tingling or numbness = "oooo"



Please answer the following questions ONLY if your job requires that: (1) 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, etc.); or (2) you use personal protective gear or equipment. If neither of these requirements applies to your job, check "N/A" here and proceed to the "Candidate Certification" section. **N/A** ☐.

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 your job?

   a. Allergy/Sensitivity Yes ☐ No ☐.

   b. Chemical(s) or substance(s) Yes ☐ No ☐.

   c. Specific work limitation(s) _____
   _____

   d. Type(s) of job accommodation(s) requested _____
   _____

8. From the list below, identify the personal protective gear/equipment that you will be required to use in your job and describe any work restriction or limitation.

Respirator? Yes ☐ No ☐.

Specific work restriction or limitation _____

Hearing Protection? Yes ☐ No ☐.

Specific work restriction or limitation _____

Gloves? Yes ☐ No ☐.

Specific work restriction or limitation _____

Protective Clothing? Yes ☐ No ☐.

Specific work restriction or limitation _____

Safety Glasses/Goggles? Yes ☐ No ☐.

Specific work restriction or limitation _____

Other Gear/Equipment? Yes ☐ No ☐.

Specific work restriction or limitation _____

9. Are you currently receiving medical treatment because of an exposure to a chemical or biological substance? Yes ☐ No ☐.

   a. Chemical or biological substance(s) _____

   b. Specific work limitation(s) _____
   _____

   c. Type(s) of job accommodation(s) requested _____
   _____

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

☐ Asbestos ☐ Dust ☐ Latex ☐ Lead

☐ Noise ☐ Pesticides ☐ Radiation ☐ Silica Powder

☐ Solvents ☐ Substances which irritated your skin or eyes

☐ Substances which cause you breathing difficulties

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Candidate 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.

Signature: _____ Date: _____

Clinician Instructions:

1. Please review this questionnaire.
2. If this is for a sedentary position, please fax a medical clearance to the Agency/Department representative or fax a request for a physical exam and/or tests.
3. If this is for a non-sedentary position, use this in conjunction with your physical examination of the employee. Fax the results to the Agency/Department representative on your medical clearance form.
4. Please retain this questionnaire in your file.

MD/HCP: _____ Date: _____

Clinician Comments: _____

_____

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