E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
ANNUAL HEALTH QUESTIONNAIRE AND SCREENING

☞ **See GENERAL INSTRUCTIONS on last page**

FOR NON-DHS/NON-COUNTY WFM

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E or C#:
E-MAIL ADDRESS:	HOME/CELL PHONE#:	DHS FACILITY: Olive View/Harbor	DEPT/WORK AREA/UNIT: Surgery
JOB CLASSIFICATION: Resident	NAME OF SCHOOL/EMPLOYER/AGENCY/SELF: UCLA	AGENCY CONTACT PERSON	AGENCY PHONE:

In accordance with Los Angeles County, Department of Health Services policy 705.001, Title 22, and CDC guidelines all contactors/students/volunteers working at the health facilities must be screened for communicable diseases annually. This form must be signed by a healthcare provider attesting all information is true and accurate OR workforce member may supply all required source documents to DHS Employee Health Services.

MEDICAL HISTORY UPDATE - Check any of the following conditions you have had since your last health evaluation.

Allergies: ☐ No Known Allergies ☐ Yes

☐ No	☐ Yes	Chest pains	☐ No	☐ Yes	Skin problem/rash
☐ No	☐ Yes	Elevated blood pressure	☐ No	☐ Yes	Exposure to communicable disease: _____
☐ No	☐ Yes	Dizziness or fainting spells			
☐ No	☐ Yes	Problems with mobility	☐ No	☐ Yes	Any surgery:_____
☐ No	☐ Yes	Backache	☐ No	☐ Yes	Other:_____
☐ No	☐ Yes	Bone or joint injury	**FOOD HANDLERS ONLY:**		
☐ No	☐ Yes	Tingling, numbness, pain in hands, wrists, elbows, or shoulders	☐ No	☐ Yes	Change in bowel habits
			☐ No	☐ Yes	Stomach or abdominal pain

TUBERCULOSIS SYMPTOM REVIEW - Complete below to the following conditions that you have had since your last health evaluation.

☐ No	☐ Yes	Cough lasting more than 3 weeks	☐ No	☐ Yes	Excessive fatigue/malaise
☐ No	☐ Yes	Coughing up blood	☐ No	☐ Yes	Recent unprotected close contact with a person with TB
☐ No	☐ Yes	Unexplained/unintended weight loss (> 5 LBS)			
☐ No	☐ Yes	Night sweats (not related to menopause)	☐ No	☐ Yes	A history of immune dysfunction or are you receiving chemotherapeutic or immunosuppressant agents
☐ No	☐ Yes	Fever/chills			
☐ No	☐ Yes	Excessive sputum			

ANNUAL INFLUENZA STATUS - if declining, you must wear a mask starting November 1st (Season is typically from July-April)

Date Received:	Facility Received at:	OR	☐ Declination Signed	Date Declined:

COVID-19 Vaccine (Provide Copy)

	Manufacturer	Lot	Vaccination Location		Date of future appointment:		
Date Received: 1st dose				OR		OR	☐ Not Vaccinated
2nd dose							

COMMENTS

_____

_____

The answers to the questions contained in this questionnaire are to the best of my knowledge. I understand that this annual health questionnaire does not take the place of regular visits to a personal, primary care physician.

Workforce Member Signature:_____Date:_____

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C No.

TUBERCULOSIS HISTORY/SCREENING (must be < 12 months from annual date)

☐ Positive TB Symptom Review with Clinical Evaluation
☐ Sent for CXR:_____(Date)
Results_____
Remove from duty ☐ No ☐ Yes_____(Date)

Document of Positive ☐ TST or ☐ BAMT/IGRA
History of BCG ☐ No ☐ Yes
History of TB/LTBI Tx ☐ No ☐ Yes
Treatment_____X_____months

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS (Indicate: - Reactor - Non-Reactor - Converter)
	ANNUAL								mm	

OR

DATE DRAWN	BAMT / IGRA	DATE RESULTED	(INITIALS)	RESULT	STATUS
	☐ GFT-Plus OR ☐ T-SPOT				

NEW CONVERSION	CXR DATE	RESULT	TREATMENT
☐ Latent TB Infection ☐ ACTIVE DISEASE- must remove from duty			☐ NO ☐ YES DATE STARTED TREATMENT: _____

RESPIRATORY FIT TESTING (Must be < 12 months from annual date)

Date:

Passed on: ☐ N95 Honeywell DF300 Standard ☐ N95 Halyard 46827/76827 Small ☐ N95 Halyard 46727/76727 Regular
☐ Maxair PAPR 700 ☐ Maxair CAPR DLC36 ☐ N/A (Job duty does not involve airborne precautions or require a respirator.)

EDUCATION/REFERRAL INFORMATION

☐ Reviewed immunization history and declination status.
☐ Recommended annual exam with primary care provider.
☐ Referred to primary care provider for treatment:_____.
☐ Referred to EHS Provider for positive findings:_____.

COMMENTS:

FOR HEALTHCARE PROVIDER:

☐ I attest that all dates and immunizations listed above are correct and accurate.

Date:	Physician or Licensed Healthcare Professional Signature:	Print Name:
Facility Name/Address:		Phone #:

OR

FOR WORKFORCE MEMBER:

☐ Required source documents attached.

Workforce Member Signature:	Date:

DHS-EHS STAFF ONLY

☐ WFM completed annual health screening.		Date of clearance:
Signature :	Print Name:	Today's Date:

GENERAL INFORMATION ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C No.

GENERAL INFORMATION

Workforce member (WFM) must complete health screening annually **by the end of the month of last health screening**. Annual health surveillance shall be performed to ascertain that WFM is free from infectious disease and is able to perform their assigned duties.

The health screening consists of:

1. Annual health questionnaire
2. Tuberculosis surveillance
3. Respiratory Fit Testing, if needed
4. Review of immunizations and provide recommended immunizations as needed, or obtain declination forms for declined immunizations

Annual health screening will be provided to County workforce members and volunteers at no charge. Non-County WFM and students must obtain health screening from their physician or school, as applicable; and provide DHS Employee Health Services (EHS) a health screening clearance certificate (**E2- Annual Health Questionnaire and Screening)** including supporting documentation(s) as applicable. Consent must be obtained from minor's parent or legal responsible person to obtain health records. Health screening for contract staff will be provided in accordance with the terms of the contract. Fees and costs for these services shall be billed to the contractor as appropriate.

No person will be allowed to work inside County medical facility without documentation of health clearance or required health screening.

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-County WFM health information.

Upon request by DHS-EHS, the non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours as applicable.

All non-DHS/non-County WFM health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635