



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:	DEPT/WORK AREA/UNIT:
JOB CLASSIFICATION:	NAME OF SCHOOL/EMPLOYER/AGENCY/SELF:	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

<input type="checkbox"/> No <input type="checkbox"/> Yes Chest pains <input type="checkbox"/> No <input type="checkbox"/> Yes Elevated blood pressure <input type="checkbox"/> No <input type="checkbox"/> Yes Dizziness or fainting spells <input type="checkbox"/> No <input type="checkbox"/> Yes Problems with mobility <input type="checkbox"/> No <input type="checkbox"/> Yes Backache <input type="checkbox"/> No <input type="checkbox"/> Yes Bone or joint injury <input type="checkbox"/> No <input type="checkbox"/> Yes Tingling, numbness, pain in hands, wrists, elbows, or shoulders	<input type="checkbox"/> No <input type="checkbox"/> Yes Skin problem/rash <input type="checkbox"/> No <input type="checkbox"/> Yes Exposure to communicable disease: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Any surgery: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Other: _____ FOOD HANDLERS ONLY: <input type="checkbox"/> No <input type="checkbox"/> Yes Change in bowel habits <input type="checkbox"/> No <input type="checkbox"/> Yes Stomach or abdominal pain
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TUBERCULOSIS SYMPTOM REVIEW - Complete below to the following conditions that you have had since your last health evaluation.

<input type="checkbox"/> No <input type="checkbox"/> Yes Cough lasting more than 3 weeks <input type="checkbox"/> No <input type="checkbox"/> Yes Coughing up blood <input type="checkbox"/> No <input type="checkbox"/> Yes Unexplained/unintended weight loss (> 5 LBS) <input type="checkbox"/> No <input type="checkbox"/> Yes Night sweats (not related to menopause) <input type="checkbox"/> No <input type="checkbox"/> Yes Fever/chills <input type="checkbox"/> No <input type="checkbox"/> Yes Excessive sputum	<input type="checkbox"/> No <input type="checkbox"/> Yes Excessive fatigue/malaise <input type="checkbox"/> No <input type="checkbox"/> Yes Recent unprotected close contact with a person with TB <input type="checkbox"/> No <input type="checkbox"/> Yes A history of immune dysfunction or are you receiving chemotherapeutic or immunosuppressant agents
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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	<input type="checkbox"/> Declination Signed	Date Declined:
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COVID-19 Vaccine (Provide Copy)

Date Received: 1 st dose	Manufacturer	Lot	Vaccination Location	OR	Date of future appointment:	OR	<input type="checkbox"/> Not Vaccinated
2 nd 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.
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TUBERCULOSIS HISTORY/SCREENING (must be < 12 months from annual date)			
<input type="checkbox"/> Positive TB Symptom Review with Clinical Evaluation	Document of Positive	<input type="checkbox"/> TST or	<input type="checkbox"/> BAMT/IGRA
<input type="checkbox"/> Sent for CXR: _____ (Date)	History of BCG	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Results _____	History of TB/LTBI Tx	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Remove from duty <input type="checkbox"/> No <input type="checkbox"/> Yes _____ (Date)	Treatment _____ X _____ months		

TUBERCULIN SKIN TEST RECORD										STATUS
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	Indicate: - Reactor - Non-Reactor - Converter
	ANNUAL								mm	

OR

DATE DRAWN	BAMT / IGRA		DATE RESULTED	(INITIALS)	RESULT	STATUS
	<input type="checkbox"/> GFT-Plus	OR	<input type="checkbox"/> T-SPOT			

NEW CONVERSION	CXR DATE	RESULT	TREATMENT
<input type="checkbox"/> Latent TB Infection <input type="checkbox"/> ACTIVE DISEASE- must remove from duty			<input type="checkbox"/> NO <input type="checkbox"/> YES DATE STARTED TREATMENT: _____

RESPIRATORY FIT TESTING		(Must be < 12 months from annual date)		
Date:	Passed on:	<input type="checkbox"/> N95 Honeywell DF300 Standard	<input type="checkbox"/> N95 Halyard 46827/76827 Small	<input type="checkbox"/> N95 Halyard 46727/76727 Regular
		<input type="checkbox"/> Maxair PAPR 700	<input type="checkbox"/> Maxair CAPR DLC36	<input type="checkbox"/> N/A (Job duty does not involve airborne precautions or require a respirator.)

EDUCATION/REFERRAL INFORMATION	
<input type="checkbox"/> Reviewed immunization history and declination status.	Recommended annual exam with primary care provider.
<input type="checkbox"/> Referred to primary care provider for treatment: _____	
<input type="checkbox"/> Referred to EHS Provider for positive findings: _____	

COMMENTS:

FOR HEALTHCARE PROVIDER:		
<input type="checkbox"/> 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:	
<input type="checkbox"/> Required source documents attached.	
Workforce Member Signature:	Date:

DHS-EHS STAFF ONLY

<input type="checkbox"/> WFM completed annual health screening.	Date of clearance:
Signature :	Print Name:
	Today's Date:

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