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Exceptional Medicine. Extraordinary Care.

MERCY OCCUPATIONAL HEALTH

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Injury / Incident - Health History Questionnaire

If you experience difficulties completing or understanding the information on this form, please notify the reception desk.

DEMOGRAPHIC INFORMATION:

Last Name _____ First Name _____ MI _____ Date of Birth ___/___/___ M / F Gender

Your Home Address _____ ( ) - Home Phone _____ S M D W Marital Status

City _____ State _____ Zip _____ ( ) - Cell Phone _____ Social Security # ___/___/___

Race: W AA/B H/L Asian Am Ind/AK HI/Pac Multi Decline
(circle one)

Company Name (Who sent you here?) _____ Emergency Contact Name _____ Relationship _____

Company Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

( ) - Company Phone _____ ( ) - Emergency Contact Phone _____

Primary Care Physician Name: _____

PRESENT INJURY, ILLNESS OR COMPLAINT:

Are you here due to an accident, illness or injury you believe is related to work? ☐ Yes ☐ No

What date did the injury occur or when did you first notice your symptoms? ___/___/___

Describe your symptoms: _____

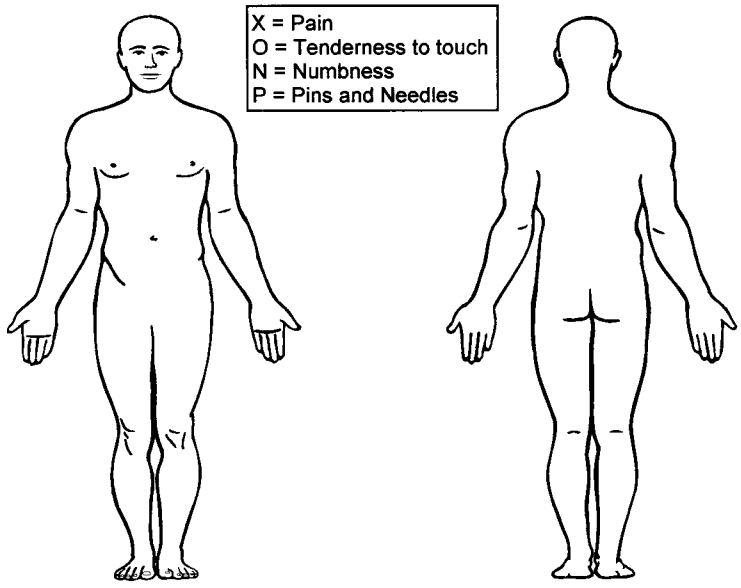
Please rate your pain on this scale:
0 1 2 3 4 5 6 7 8 9 10
None----------Most Possible
☺ 😐 ☹

Describe how your problem happened: _____

Have you had similar problems in the past? Please describe.

Indicate on the drawings the location of your symptoms

X = Pain
O = Tenderness to touch
N = Numbness
P = Pins and Needles



Handedness: ☐ Right ☐ Left

HEALTH / HISTORY: MEDICATIONS: List all medicines you are CURRENTLY taking.

Name of Medication	Dosage	Reason

ALLERGIES: ☐ No Allergies ☐ Medical allergies

Please specify: _____

Name: _____
Employer: _____
MR#: ___ - ___ - ___
DOB: ___/___/___

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PAST MEDICAL HISTORY:

Have you **EVER** had.... check all that apply.

- ☐ Eye Problems/Foreign Body
- ☐ Color Blindness
- ☐ Ear or Hearing Problems
- ☐ Nutrition Problems
- ☐ Nose Problems
- ☐ Mouth/Oral Problems
- ☐ Lung Problems
- ☐ Lung Infection
- ☐ Asthma
- ☐ Emphysema
- ☐ Pacemaker/Stent
- ☐ Angina/Chest Pain
- ☐ Heart Disease
- ☐ Metal in any part of your body
- ☐ High Blood Pressure
- ☐ Liver Problems
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach Problems
- ☐ Stomach Ulcers
- ☐ Colitis
- ☐ Urinary Problems
- ☐ Kidney/Bladder Infection
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Bleeding Problems
- ☐ Skin Problems
- ☐ Filed a Worker's Comp. Claim
- ☐ Joint Replacement
- ☐ Arthritis
- ☐ Cancer
- ☐ Radiation/Chemo
- ☐ Carpal Tunnel
- ☐ Diabetes
- ☐ Gout
- ☐ Hay Fever
- ☐ Hives
- ☐ Neurological Problems
- ☐ Head/Spine Problems
- ☐ Prior Back Strains
- ☐ Ruptured Disc
- ☐ Received an impairment rating or permanent restriction
- ☐ Migraines
- ☐ Seizures
- ☐ Sports Injuries
- ☐ Muscle Problems
- ☐ Sprains or Strains
- ☐ Any Prior Work Injury
- ☐ Chiropractic Care
- ☐ Tendonitis
- ☐ Depression
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Hernia
- ☐ Loss of Consciousness
- ☐ Other serious injury, illness, hospital stay, or operation

Please explain: _____

_____

Last Tetanus ____/____/____ Hepatitis B Titer ____/____/____

CURRENT MEDICAL SYMPTOMS: Please check any **CURRENT** problems you have on the list below:

Constitutional
- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss/gain
- ☐ Change in energy/weakness
- ☐ Frequent thirst or urination

Eyes
- ☐ Sensitivity to Light
- ☐ Change in Vision

Ears/Nose/Throat/Mouth
- ☐ Difficult hearing/ringing in ears
- ☐ Problems with teeth/gums
- ☐ Hay fever/allergies

Cardiovascular
- ☐ Chest pain/discomfort
- ☐ Irregular heart beat
- ☐ High Blood Pressure

Respiratory
- ☐ Cough/wheeze
- ☐ Difficulty breathing

Gastointestinal
- ☐ Abdominal Pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

Genitourinary
- ☐ Nighttime urination
- ☐ Leaking Urine

Musculo-skeletal
- ☐ Muscle/joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle weakness

Blood/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Unexplained lumps
- ☐ Diabetes

Neurological
- ☐ Headaches
- ☐ Dizziness/light-headedness
- ☐ Numbness
- ☐ Memory Loss
- ☐ Loss of Coordination

Psychiatric
- ☐ Anxiety/stress
- ☐ Problems with sleep
- ☐ Depression

Other
- ☐ _____

SOCIAL & WORK HISTORY:

Current Job/Position:_____ Circle one: Full Time/Part Time/Temporary Start Date: _____

Please list all past or other current jobs, including military service and farm work.

Starting	Ending	Employer	Job duties
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List hobbies _____

Have you have **EVER** smoked: ☐ Never Cigarettes/Pipe/Cigar packs/day: ____ How many years? ____ Date quit _____

Do you feel safe at home? ☐ Yes ☐ No

If you were experiencing violence in your home, would you know where to go for help? ☐ Yes ☐ No

I certify I have accurately completed this form to the best of my knowledge.

Patient Signature _____ **Date** ____/____/____

PROVIDER COMMENT:

_____ Date _____ Time _____

☐ **Charles Buck, MD** ☐ **Tina Stec, MD** ☐ **Theophilus Oyelayo, MD**
☐ **Thomas Dean, PA-C**

Name: _____
Employer: _____
MR#: _____ - _____ - _____
DOB: _____ / _____ / _____

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