MERCY IOWA CITY
Exceptional Medicine. Extraordinary Care.

MERCY OCCUPATIONAL HEALTH
www.MercyOccupationalHealth.org

Coral West Medical Center
2769 Heartland Drive, Suite 205
Coralville, IA 52241
(319) 339-3921
Fax (319) 339-3858
Toll Free (800) 637-2942 x 3921

Muscatine Medical Center
2104 Cedarwood Drive, Suite 102
Muscatine, IA 52761
(563) 263-3921
Fax (563) 264-2525
Toll Free (877) 863-3921

IME/Assume Care - 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 (__/__/__) | Gender M / F

Your Home Address | Home Phone (___) ___-____ | Marital Status S M D W

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 | Date of Birth ___/___/____

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: _____

Are your symptoms now (circle) **BETTER** **WORSE** or the **SAME** since they started?

Describe how your problem happened: _____

What other doctors have you seen so far for this problem? _____

List testing you have had for this problem. ☐ X-rays ☐ CT scan ☐ EMG/Nerve conduction ☐ MRI
☐ Other _____

List treatments you have had for this problem. ☐ medications ☐ splints ☐ physical therapy ☐ injections
☐ Surgery ☐ Other _____

What makes your problem feel better? _____

What makes your problem feel worse? _____

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

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What parts of your job make the problem worse? _____

_____

What activities of daily living are you unable to do because of your symptoms? (Include hobbies and recreational activities) _____

_____

List any current work or activity restrictions. _____

_____

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

_____

Have you ever previously filed a workers compensation claim?

☐ No ☐ Yes Explain: _____

Have you previously received an impairment rating or permanent work restriction?

☐ No ☐ Yes Explain: _____

Have you ever been off work for more than 3 days because of an illness or injury related to work?

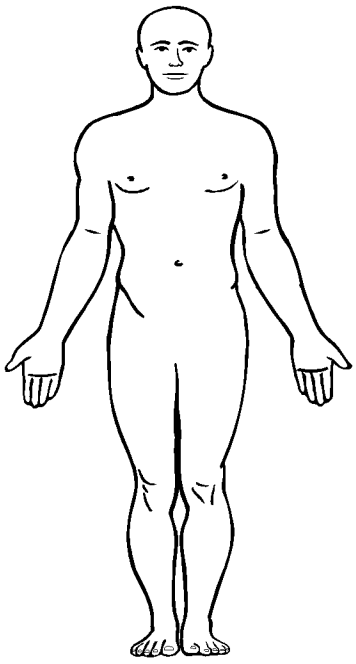
☐ No ☐ Yes Explain: _____

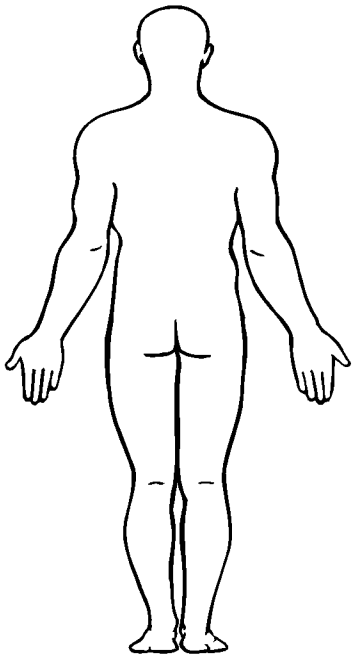
Have you ever changed jobs or work assignments because of a health problem or injury?

☐ No ☐ Yes Explain: _____

Please indicate on the drawings the location of your symptoms:

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





Please rate your pain on this scale:

0 1 2 3 4 5 6 7 8 9 10

None----------Most Possible

☺ 😐 ☹

Are you right handed or left handed?

Right ***Left***

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HEALTH / HISTORY:

Last Tetanus _____/_____/_____

ALLERGIES:

☐ No Allergies ☐ Medication ☐ Food ☐ Environmental

Please specify: _____

PAST MEDICAL HISTORY:

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

- ☐ Eye Problems/Foreign Body
- ☐ Liver Problems
- ☐ Ear or Hearing Problems
- ☐ Hepatitis
- ☐ 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
- ☐ Arthritis
- ☐ Jaundice
- ☐ Radiation/Chemo
- ☐ Stomach Problems
- ☐ Stomach Ulcers
- ☐ Colitis
- ☐ Urinary Problems
- ☐ Kidney/Bladder Infection
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Bleeding Problems
- ☐ Skin Problems
- ☐ Joint Replacement
- ☐ Seizures
- ☐ Cancer
- ☐ Muscle Problems
- ☐ Carpal Tunnel
- ☐ Diabetes
- ☐ Gout
- ☐ Hay Fever
- ☐ Hives
- ☐ Neurological Problems
- ☐ Head/Spine Problems
- ☐ Back Pain
- ☐ Ruptured Disc
- ☐ Migraines
- ☐ Loss of Consciousness
- ☐ Sports Injuries
- ☐ Neck Problems
- ☐ Sprains or Strains
- ☐ Any Prior Work Injury
- ☐ Chiropractic Care
- ☐ Tendonitis
- ☐ Depression
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Hernia
- ☐ Sleep Disorder

Please explain: _____

_____

SERIOUS INJURIES, ILLNESS, HOSPITAL STAYS OR OPERATIONS: List and give dates.

_____

_____

_____

CURRENT MEDICAL CONDITIONS: 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
- ☐ _____

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MEDICATIONS: List all medicines you are **CURRENTLY** taking.

Name of Medication	Dosage	Reason

WORK HISTORY:

Employer at the time when your problem began _____

Full Time Part Time Temporary Start Date: _____

Type of Job/Position/Responsibilities: _____

Did you work elsewhere in addition to this job? If so, where? _____

Are/were you satisfied with this job? □ Yes □ No

If no, please list any specific problems you had with the job. _____

Current employer (if different) _____ Full Time Part Time Start Date: _____

Type of Job/Position/Responsibilities: _____

Are you working elsewhere in addition to your current job? If so, where? _____

If you are not working now, when did you last work? _____

Please list in order all jobs including military service and farm work. This information is used to determine the type of work you have done in the past.

Starting (mo/yr)	Ending (mo/yr)	Employer	Job duties

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SOCIAL HISTORY:

If married, is your spouse currently employed? ☐ Yes ☐ No If yes, where? _____

Where were you born? _____

Please circle the highest grade or year of school you attended:

1 2 3 4 5 6 7 8	9 10 11 12	GED	1 2 3 4 5 6+
	High school		College

List your hobbies: _____

Are you currently a smoker? ☐ Yes, currently ☐ No ☐ Quit date _____

Circle if you smoked: Cigarettes Pipe Cigar Average packs/day: _____ How Many Years? _____

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

Other COMMENTS:

_____

_____

_____

_____

_____

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

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

Thank you

PROVIDER COMMENT:

_____ Date _____ Time _____

☐ **Charles Buck, MD** ☐ **Tina Stec, MD** ☐ **Sarvenaz Jabbari, MD**

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