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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.**

Patient Information

➢**Please provide a photo ID to be scanned.**

Social Security #:	*Sex:*	*Employment Status:*
Full Name:	*DOB:*	*Employer:*
Address:	*Marital Status:*	*Address:*
	Race/Ethnicity:	
City/State/Zip:	*Language:*	*Home #:*
Email: ❒None		*Cell #:*
Primary Care Provider:		*Work #:*

EMERGENCY CONTACT

Name:	*Language:*	*Cell #:*
Sex: *DOB:*	*Home #:*	*Work #:*
Patient's relationship to Emergency Contact:		

Pharmacy:	*Mothers Maiden Name:*

Present Injury, Illness, Or Complaint

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

When did the injury occur or when did you first notice your symptoms? _____/_____/_____

Rate your pain on this scale: 0 1 2 3 4 5 6 7 8 9 10
☺ 😐 ☹

Describe your symptoms:

_____
_____
_____

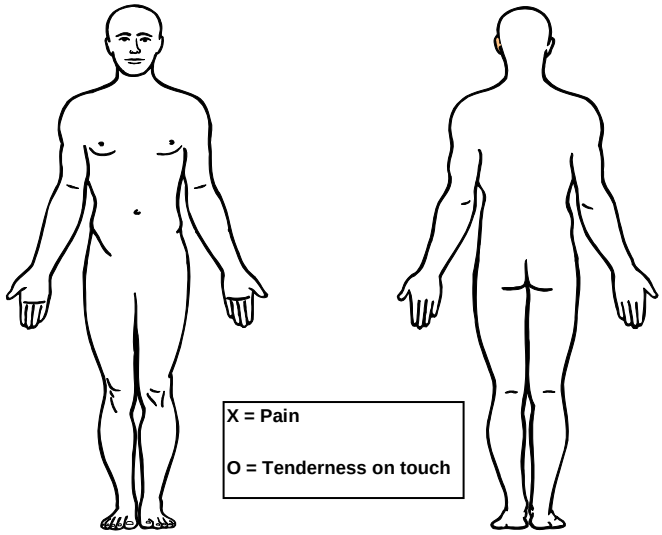
Describe how the problem happened:

_____
_____
_____

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

_____
_____
_____

Indicate on the drawing the location of your symptoms:



Handedness: ☐ Left ☐ Right

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Health History

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

Allergies ☐ No Allergies ☐ Medication ☐ Food ☐ Environmental

Please specify:_____

Medications: List all medicines you are **Currently** taking.

Name of Medication	Dosage	Reason

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
- ☐ Joint Replacement
- ☐ Arthritis
- ☐ Cancer
- ☐ Radiation/Chemo
- ☐ Carpal Tunnel
- ☐ Diabetes
- ☐ Gout
- ☐ Hay Fever
- ☐ Hives
- ☐ Neurological Problems
- ☐ Head/Spine Problems
- ☐ Prior Back Strains
- ☐ Ruptured Disc
- ☐ Migraines
- ☐ Seizures
- ☐ Sports Injuries
- ☐ Muscle Problems
- ☐ Sprains or Strains
- ☐ Any Prior Work Injury
- ☐ Chiropractic Care
- ☐ Tendonitis
- ☐ Depression
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Hernia
- ☐ Loss of Consciousness

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
- ☐ _____

INJURY/INCIDENT – HEALTH HISTORY QUESTIONNAIRE

Social & Work History:

Current Employer:_____ Start Date:_____

Current Position: _____ For this job are you: Full Time Part Time Temporary

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

Start	End	Employer	Job duties

Are you working elsewhere in addition to this job? _____

Do you have any hobbies? _____

Are you currently a smoker? ☐ Yes ☐ No

Circle if you have **Ever** used Tobacco: Cigarettes Pipe Cigar Average packs/day: _____How Many Years? _____

Attestation:	I certify that I have completed this form to the best of my knowledge and acknowledge that **any work restrictions given to me by the provider apply to all my work and non-work related activities.**	**Initial:**	_____
HIPAA Policy:	I acknowledge that I have received or been offered a copy of Mercy Services HIPAA Privacy Policy.	**Initial:**	_____
Authorization To Release:	I hereby authorize my physician and/or records acquired during the course of examination or treatment of the work-related injury/illness identified above to my employer, their insurance carrier, case manager or designated representative for the purpose of coverage determination and processing payment/insurance claims.	**Initial:**	_____
Financial Policy:	I hereby authorize payment for charges incurred for services rendered by «PracticeName», directly to the physician and/or «PracticeName». I realize any non-covered services will be my responsibility.	**Initial:**	_____
Patient Signature:	_____	**Date:**	_____
Provider		**Date:**	_____
Comment:			
Provider Signature:	_____ «ProviderName»	**Time:**	_____