Workers' Comp Injury Health History Questionnaire

Last Name:________________________________ First: ____

Address: ____ City: ____________________________

State____________ Zip Code_____________________ Social Security #: ________________________

Date of Birth: ________________________ Gender: M / F (Circle)

Race: (optional) African American/ Caucasian/ Hispanic/Asian / Other

Home Phone:____________________________ Cell Phone:___________________________________

Employer: _________________________________Occupation: _______________________________

Employer Phone #: _________________________ Length of Employment: _______________________

Contact Person/Supervisor: _____________________Supervisor Phone Number: ____________________

I authorize this treating facility to perform any and all tests or procedures as deemed necessary by the attending physician and/or employer. I authorize the release of medical information concerning my care to another medical facility or medical provider for the purpose of continuing my care, to my employer and their workers' compensation carrier. I understand that this information may be used for the purpose of informing and communicating to other physicians, organizations and professionals regarding the health/medical services provided to me. I agree to allow St. Francis Hospital & Medical Center to bill my health insurance if my claim is denied. I understand that I am responsible for any remaining balance/charges incurred at St. Francis Hospital & Medical Center. I understand that I will be billed on a monthly basis. I further understand that my employer will be notified if I am unable to keep a scheduled appointment.

Employee/Patient Signature: ______________________________________ Date:__________________

Patient Name: ________________________ Date of Birth: _________________Date: _____________

1. Have you previously received treatment in this facility, or in any other occupational health facility for any reason? ☐ Yes ☐ No If yes, when?____

Please answer the following questions about the injury you are here for today:

2. How did this injury occur?:
____
____
3. Date of Injury: ______________________________ Time of Injury: __________________________
4. Have you been treated previously (ER, Clinic) for this injury? ________
5. Did the symptoms come on suddenly or did they develop gradually? ☐ Suddenly ☐ Gradually
6. What words best describes your symptoms? ☐Aching ☐Constant ☐Sharp ☐ Dull ☐Comes & Goes
7. Does anything aggravate the symptoms or make them worse? _____________________________
8. Does anything lessen the symptoms or make them better? _______________________________
9. Describe any remedies you may have used and whether they were effective? _________________
____
10. Describe any difficulties you are having with activities at home or at work?__________________
____
11. Have you ever had a similar problem in the past? ☐ Yes ☐ No
12. Have you seen other health care providers for this problem? ☐ Yes ☐ No If yes, please describe when it occurred and the treatment provided:____
____

Do you now have or have you ever had:

High Blood Pressure	☐Yes	☐ No	Arthritis	☐Yes	☐ No
Diabetes	☐Yes	☐ No	Epilepsy/Seizures	☐Yes	☐ No
Heart Disease/High Cholesterol	☐Yes	☐ No	Lung Disease/TB/Asthma	☐Yes	☐ No
Kidney Disease	☐Yes	☐ No	Cancer	☐Yes	☐ No
Carpal Tunnel	☐Yes	☐ No	Anemia/Bleeding/Bruising	☐Yes	☐ No
Psychiatric Illness	☐Yes	☐ No	Hernia	☐Yes	☐ No
Broken Bones/Back/Neck/ Injury	☐Yes	☐ No	Joint/Muscle injury	☐Yes	☐ No
Work Restrictions/ Disability Rating	☐Yes	☐ No	Drug/Alcohol Addiction	☐Yes	☐ No
Hospitalizations/Surgeries	☐Yes	☐ No	Smoke Cigarettes	☐Yes	☐ No
Ulcer/GERD/Inflammatory Bowel	☐Yes	☐ No	How many per day? ______________		
Skin diseases	☐Yes	☐ No	Number of years? ________________		

Explain any yes answers: ____
____
____

Last Tetanus: ______________________ Last Menstrual Period: ___________________ *(Females only)*

List **all** the **Medications**, Vitamins or Supplements you are presently taking, **both** prescription and over the counter, indicate dosages: ____
____

List any **Allergies** to medication, food, latex, chemicals: ☐ None
____
____