

Initial Visit Medical History - Injury

Please PRINT Clearly:

Date: _____ Time: _____
 Patient Name: _____ Employer: _____
 Date of Injury/Exposure: _____ How long at this job? _____
 Time of Injury /Exposure: _____ Job "Function"? _____
 Start Time on Day of Injury: _____ Date of Birth: _____ Age: _____

Complaint: (What is hurt?) 1. _____ 2. _____ 3. _____
 (Indicate right or left part of body that is injured)

How did this happen? _____

What treatment have you done so far? _____

Have you injured this before? Y N When? _____ Work Related? Y N

Social & Family History: Do you smoke? _____ How much? _____
 Do you drink? _____ How much? _____
 Do you have a history of drug or alcohol abuse? _____
 Do any medical problems run in your family? No ___ Yes ___ (list below)

Personal Medical History: Do You Have Any Allergies? YES / NO (Circle)

LIST ALLERGIES HERE

1. _____ 2. _____ 3. _____ 4. _____

Current Medications: 1. _____ 2. _____ 3. _____ 4. _____

Medical Conditions? _____

Surgeries? _____

Work Injuries? _____

Have you had or currently have any of the following conditions: (circle all that apply and comment)

(Asthma? Diabetes? High Blood Pressure? Stroke?) _____

(Angina? Heart Attack? Stomach Ulcer? Kidney?) _____

(Acid Reflux? Sickle Cell? Thalassemia? Liver) _____

(Valve Disease? Bleeding Disorder? G6PD?) _____

(Immune disorder?) _____

(Psychiatric disorder? Neurologic problem? Epilepsy?) _____

Other Medical Problems? _____

(Females) Your last period? _____

What hand do you write with? _____

Do you work for any other person or employer? Yes / No

If yes, when was the last time you worked (hour and day) _____ What kind of work? _____

Do you do any physical activity outside of work? (Sports / remodeling / Hobbies?) Yes / no

If yes, when was the last time? (hour and day) _____ What kind of physical activity? _____

TETANUS: How long has it been since your last tetanus shot? _____

By signing I state that the injury or exposure I sustained occurred as stated above, and that all statements made are truthful and accurate.

Patient Signature: _____ Date: _____ Reviewer _____