



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:

Form with fields for Last Name, First Name, MI, Date of Birth, Gender, Home Address, City, State, Zip, Home Phone, Cell Phone, Social Security #, Race, Company Name, Emergency Contact Name, Relationship, Company Address, City, State, Zip, Company Phone, Emergency Contact Phone, Religious Preference, and 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?

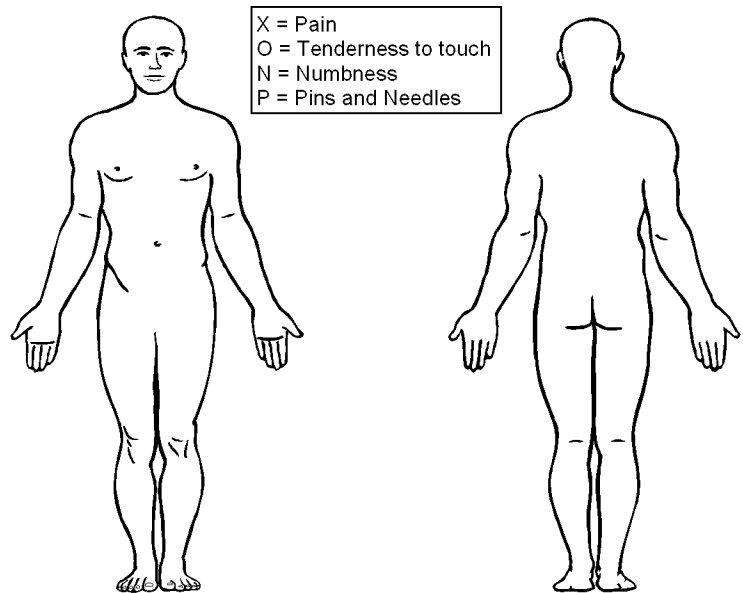
Describe your symptoms:

Pain scale: 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



Handedness: Right Left

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

Table with columns: Name of Medication, Dosage, Reason

ALLERGIES: No Allergies Medical allergies
Please specify:

Form with fields for Name, Employer, MR#, and DOB. Includes OFFICE USE ONLY stamp.

**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, Other serious injury, illness, hospital stay, or operation, 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

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
Gastrointestinal: 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.

Table with 4 columns: Starting, Ending, Employer, Job duties. Includes three rows of blank lines for data entry.

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:**

\_\_\_\_\_  
 Charles Buck, MD  Tina Stec, MD  Ted Koerner, MD  Thomas Dean, PA-C

Form box containing fields for Name, Employer, MR#, and DOB. Includes a stamp that says 'OFFICE USE ONLY'.