



Exceptional Medicine.
Extraordinary Care.

MERCY OCCUPATIONAL HEALTH

www.MercyOccupationalHealth.org

Mercy Medical Plaza
540 E Jefferson Street, Suite 205
Iowa City, IA 52245
(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:

Form with fields for Last Name, First Name, MI, Date of Birth, Gender, Home Address, City, State, Zip, Home Phone, Cell Phone, Marital Status, Social Security #, Race, Company Name, Emergency Contact Name, Relationship, Company Address, Emergency Contact Address, City, State, Zip, 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: \_\_\_\_\_

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? \_\_\_\_\_

Box containing fields for Name, Employer, MR#, and DOB.



Exceptional Medicine.
Extraordinary Care.

MERCY OCCUPATIONAL HEALTH

www.MercyOccupationalHealth.org

Mercy Medical Plaza
540 E Jefferson Street, Suite 205
Iowa City, IA 52245
(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

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?

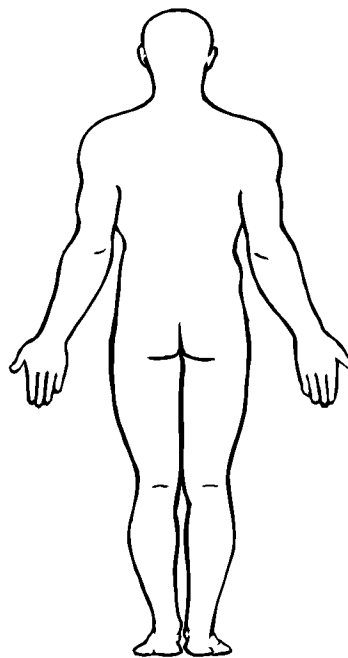
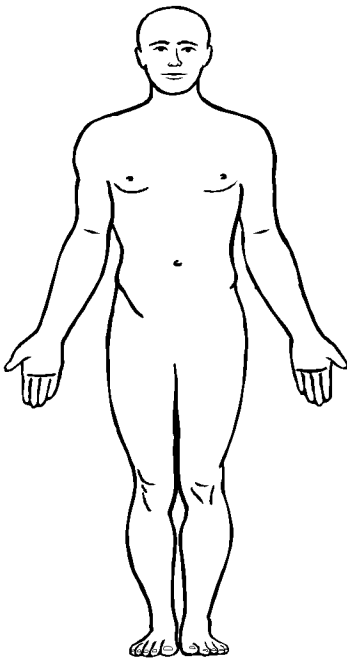
[ ] No [ ] Yes Explain: \_\_\_\_\_

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

Name: \_\_\_\_\_
Employer: \_\_\_\_\_
MR#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



Exceptional Medicine.
Extraordinary Care.

MERCY OCCUPATIONAL HEALTH

www.MercyOccupationalHealth.org

Mercy Medical Plaza
540 E Jefferson Street, Suite 205
Iowa City, IA 52245
(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

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/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

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

\_\_\_\_\_

Name: \_\_\_\_\_
Employer: \_\_\_\_\_
MR#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



Exceptional Medicine.
Extraordinary Care.

MERCY OCCUPATIONAL HEALTH

www.MercyOccupationalHealth.org

Mercy Medical Plaza
540 E Jefferson Street, Suite 205
Iowa City, IA 52245
(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

MEDICATIONS: List all medicines you are CURRENTLY taking.

Table with 3 columns: Name of Medication, Dosage, Reason. Includes 5 rows of blank lines for data entry.

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.

Table with 4 columns: Starting (mo/yr), Ending (mo/yr), Employer, Job duties. Includes 10 rows of blank lines for data entry.

Name: \_\_\_\_\_
Employer: \_\_\_\_\_
MR#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



Exceptional Medicine.
Extraordinary Care.

MERCY OCCUPATIONAL HEALTH

www.MercyOccupationalHealth.org

Mercy Medical Plaza
540 E Jefferson Street, Suite 205
Iowa City, IA 52245
(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

FAMILY MEDICAL HISTORY:

Please describe medical problems in your family. (If deceased, list cause of death and age)

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

SOCIAL HISTORY:

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed/er

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

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 [ ] Theodore Koerner, MD

Name: \_\_\_\_\_
Employer: \_\_\_\_\_
MR#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_