



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

Physical - 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, Address, City, State, Zip, Company Phone, Emergency Contact Phone, Religious Preference, and Primary Care Physician Name.

HEALTH / HISTORY:

Last Tetanus / / Hepatitis B Titer / /

ALLERGIES:

No Allergies Medication Food Environmental

Please specify:

PAST MEDICAL HISTORY:

Have you EVER had... check all that apply.

- List of medical conditions with checkboxes: 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.

Blank lines for listing serious injuries, illness, hospital stays or operations.

Name:
Employer:
MR#:
DOB: / /



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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

MEDICATIONS: List all medicines you are CURRENTLY taking.

Name of Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL & WORK HISTORY:

For this job are you: Full Time Part Time Temporary Start Date: _____

Type of Job/Position: _____

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.

Starting	Ending	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 smoked: Cigarettes Pipe Cigar Average packs/day: _____ How Many Years? _____

Name: _____

Employer: _____

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WORK RELATED HEALTH HISTORY: Please circle any substance you have been exposed to during work or hobby activity.

- Ammonia, Asbestos, Beryllium, Cadmium, Coal dust, Cold (severe), Excessive dust, Fiberglass, Heat (severe), Isocyanates/urethanes, Ketones, Lasers, Lead, Mercury, Noise (loud), Pesticides, Silica sand, Solvents, Spray painting, Styrene, Vibration, Welding fumes, X rays, Other

Have you developed or had any known health problems due to your present or past employment? (include: injuries, illnesses, and possible allergies).

[] No [] Yes Explain: _____

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: _____

Have you ever worked with a substance which caused you to break out in a rash?

[] No [] Yes Explain: _____

Have you ever worked with a substance which caused you trouble breathing? (cough, shortness of breath, wheezing, etc)

[] No [] Yes Explain: _____

Do you experience pain/discomfort in your back or have you been under a doctor/chiropractor's care for back problems?

[] No [] Yes Explain: _____

Do you experience pain or discomfort in your neck, shoulder, elbow, wrist or hand such as tendonitis, carpal tunnel syndrome or have you been under a doctor's care for such problems?

[] No [] Yes Explain: _____

Do you have a hobby, craft or business that you do outside of this job?

[] No [] Yes Explain: _____

Do you use any assistive devices such as prostheses, braces, artificial limbs, artificial eye, cane, or hearing aid?

[] No [] Yes Explain: _____

Do you have any known physical or mental impairments, limitations, or disabilities?

[] No [] Yes Explain: _____

Have you been treated for psychiatric, alcohol or drug related illnesses?

[] No [] Yes Explain: _____

Have you ever had any type of reaction when wearing latex gloves?

[] No [] Yes Explain: _____

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FAMILY MEDICAL HISTORY: Please describe medical problems in your family:
(If deceased, list cause of death and age)

Mother _____
Father _____
Sisters _____
Brothers _____

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 that the above answers are true and correct to the best of my knowledge. Any deliberate falsification of a response may be grounds for dismissal by the employer.

Patient Signature _____ Date ____/____/____

PROVIDER COMMENT:

_____, Date _____ Time _____
[] Charles Buck, MD [] Tina Stec, MD [] Ted Koerner, MD [] Thomas Dean, PA-C

Name: _____
Employer: _____
MR#: _____ - _____ - _____
DOB: ____/____/____