Bayfront
Convenient Care Clinics
WALK IN MEDICAL CARE

WORKERS' COMPENSATION PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

History of Current Medical Problem

Describe your medical problem: _____

_____

When did this problem begin and how did your injury occur? _____

_____

How is this problem related to your employment? _____

_____

Have you had the same or similar problems in the past? _____

_____

What treatment have you received for this problem already? _____

_____

Personal Medical History

MEDICATION ALLERGIES: _____

CURRENT MEDICATIONS: _____

List all illnesses and injuries you have experienced inthe past 10 years: _____

_____

List all surgical procedures: _____

Have you ever had stomach ulcers or other significant gastrointestinal problems? _____

_____

Do you smoke? _____

Do you consume Alcohol? _____

Are there diseases that run in your family? _____

DOCTOR / ARNP INITIAL'S: _____ DATE: _____

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OCCUPATIONAL HISTORY

HAVE YOU EVER WORKED WITH:

	YES	NO	COMMENTS
CHEMICALS	_____	_____	_____
VAPORS/GASES	_____	_____	_____
METALS/MINERALS	_____	_____	_____
FUMES	_____	_____	_____
RADIATION	_____	_____	_____
CHEMOTHERAPY	_____	_____	_____
DUST	_____	_____	_____
VIBRATIONS	_____	_____	_____
LOUD NOISES	_____	_____	_____
ASBESTOS	_____	_____	_____

HAS YOUR WORK EVER BEEN LIMITED OR RESTRICTED ON ACCOUNT OF YOUR HEALTH? YES _____ NO _____

HAVE YOU EVER LOST TIME FROM WORK DUE TO ILLNESS OR INJURY DURING THE PAST TWO YEARS? YES _____ NO _____

HAVE YOU EVER FILED A COMPENSATION CLAIM OR RECEIVED BENEFITS AS A RESULT OF A WORK RELATED INJURY OR ILLNESS? YES _____ NO _____

HAVE YOU EVER RECEIVED DISABILITY BENEFITS FROM AN EMPLOYER OR SOCIAL SECURITY? YES _____ NO _____

HAVE YOU EVER BEEN DISQUALIFIED FOR DUTY IN OR DISCHARGED FROM THE ARMED FORCES FOR MEDICAL REASONS? YES _____ NO _____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE GIVE AN EXPLANATION OF THE CIRCUMSTANCES BELOW. BE SURE TO INCLUDE SPECIFIC DETAILS.

_____

_____

_____

_____

_____

DOCTOR / ARNP INITIAL'S: _____ DATE: _____

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Review of Systems

NAME: _____ DATE: _____

Constitutional Symptoms
Good general health lately ____ No ____ Yes
Recent weight change ____ No ____ Yes
Fever ____ No ____ Yes
Fatigue ____ No ____ Yes

Ears/Nose/Mouth/Throat
Hearing loss or ringing ____ No ____ Yes
Earaches or drainage ____ No ____ Yes
Chronic sinusitis or rhinitis ____ No ____ Yes
Nose bleeds ____ No ____ Yes
Bleeding gums ____ No ____ Yes
Bad breath or taste ____ No ____ Yes
Sore throat or voice change ____ No ____ Yes
Difficulty swallowing ____ No ____ Yes

Neurological
Frequent headaches ____ No ____ Yes
Light headed / dizzy ____ No ____ Yes
Convulsions / seizures ____ No ____ Yes
Numbness / tingling ____ No ____ Yes
Tremors ____ No ____ Yes
Paralysis or stroke ____ No ____ Yes
Head Injury ____ No ____ Yes

Musculoskeletal
Joint pain ____ No ____ Yes
Joint stiffness or swelling ____ No ____ Yes
Weakness joints / muscles ____ No ____ Yes
Muscle pain or cramps ____ No ____ Yes
Back pain ____ No ____ Yes
Cold extremities ____ No ____ Yes
Difficulty walking ____ No ____ Yes

Cardiovascular
Heart trouble ____ No ____ Yes
Chest pain ____ No ____ Yes
Palpitations ____ No ____ Yes
Swelling feet, ankles, hands ____ No ____ Yes
Heart murmur ____ No ____ Yes
Hypertension ____ No ____ Yes

Endocrine
Thyroid disease ____ No ____ Yes
Diabetes ____ No ____ Yes
Excessive thirst/urination ____ No ____ Yes
Heat/cold intolerance ____ No ____ Yes

Gastrointestinal
Loss of appetite ____ No ____ Yes
Change in bowel movement ____ No ____ Yes
Painful bowel movement ____ No ____ Yes
Nausea/vomiting ____ No ____ Yes
Frequent diarrhea ____ No ____ Yes
Constipation ____ No ____ Yes
Rectal bleeding ____ No ____ Yes
Blood in stool ____ No ____ Yes
Abdominal pain ____ No ____ Yes
Peptic ulcer ____ No ____ Yes

Psychiatric
Memory loss or confusion ____ No ____ Yes
Nervousness/insomnia ____ No ____ Yes
Depression/anxiety ____ No ____ Yes
Mental illness ____ No ____ Yes
Psychiatric hospitalization ____ No ____ Yes

Eyes
Eye disease or injury ____ No ____ Yes
Wear glasses/contacts ____ No ____ Yes
Blurred/double vision ____ No ____ Yes
Glaucoma ____ No ____ Yes

Genitourinary
Frequent urination ____ No ____ Yes
Burning / painful urination ____ No ____ Yes
Blood in urine ____ No ____ Yes
Incontinence / dribbling ____ No ____ Yes
Difficulty urinating ____ No ____ Yes
Kidney stones ____ No ____ Yes
Sexual difficulty ____ No ____ Yes
Male testicle pain ____ No ____ Yes
Female pain with period ____ No ____ Yes
Female irregular period ____ No ____ Yes
Female vaginal discharge ____ No ____ Yes

Respiratory
Chronic / frequent cough ____ No ____ Yes
Spitting up blood ____ No ____ Yes
Shortness of breath ____ No ____ Yes
Asthma/wheezing ____ No ____ Yes

Skin
Rash or itching ____ No ____ Yes
Change in skin color ____ No ____ Yes
Change in hair / nails ____ No ____ Yes
Varicose veins ____ No ____ Yes
Breast pain ____ No ____ Yes
Breast lump ____ No ____ Yes
Breast discharge ____ No ____ Yes

Hematological / Lymphatic
Slow to heal after cuts ____ No ____ Yes
Bleed / bruise easily ____ No ____ Yes
Anemia / transfusion ____ No ____ Yes
Phlebitis ____ No ____ Yes
Swollen gland ____ No ____ Yes
Hepatitis ____ No ____ Yes

Allergic / Immunologic
Latex allergy ____ No ____ Yes
Food allergy ____ No ____ Yes
Environmental allergy ____ No ____ Yes

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