



## 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 in the 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: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

### 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.

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DOCTOR / ARNP INITIAL'S: \_\_\_\_\_ DATE: \_\_\_\_\_

## 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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