OCCUPATIONAL HEALTH
Injured Worker's Health History

Please answer the following questions:

Name of your family physician: _____

Name of your Pharmacy: _____

Have you been seen by any physician for your current injury? ☐**Yes** ☐**No**

If yes, whom did you see? _____

What did they recommend? _____

_____

Have you taken any medication for your injury? ☐**Yes** ☐**No**

If yes, what did you take? _____

List any other jobs/employers that you have: _____

Past Medical History:
What health problems do you have? Include any problems in the past with bones, joints, muscle pain and motion limitations, numbness or weakness. _____

_____

Past Surgical History: _____

_____

Have you ever had an injury, illness, or pain involving the same body part as this injury? ☐**Yes** ☐**No**
If yes, please describe and list treatment:

_____

_____

Clinical Comments

Patient ID

Please list all medication, vitamins and supplements you are currently taking:

NAME OF MEDICATION________________________ **NAME OF MEDICATION**________________________

DOSE:________________________ **DOSE:** ________________________

HOW OFTEN:________________________ **HOW OFTEN:** ________________________

NAME OF MEDICATION________________________ **NAME OF MEDICATION**________________________

DOSE:________________________ **DOSE:** ________________________

HOW OFTEN:________________________ **HOW OFTEN:** ________________________

NAME OF MEDICATION________________________ **NAME OF MEDICATION**________________________

DOSE:________________________ **DOSE:** ________________________

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NAME OF MEDICATION________________________ **NAME OF MEDICATION**________________________

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NAME OF MEDICATION________________________ **NAME OF MEDICATION**________________________

DOSE:________________________ **DOSE:** ________________________

HOW OFTEN:________________________ **HOW OFTEN:** ________________________

SIGN:

Patient Printed Name______________________________**Date of Birth**____________

Patient Signature________________________________**Date**__________**Time**____________

Office Use
Reviewed by:________________________________**Date**__________**Time** ____________

Patient ID