



SSM WorkHealth

A Service of SSM Rehabilitation Hospital

PATIENT MEDICAL HISTORY

REASON FOR VISIT: Injury/Illness RTW/Fit for Duty Post Offer PE Annual PE

Last Name: _____ First Name: _____ M.I.: _____ Date: ____/____/____

Date of Birth: ____/____/____ Male Female SSN or Employer ID: _____

Date of Injury: ____/____/____ Time of Injury: _____ am / pm Location: _____

Employer: _____ Job Title: _____ Date of Hire: ____/____/____

QUESTIONS 1-5 FOR INJURIES ONLY

1. How did the injury or illness occur? _____

2. What have you done to treat the illness or injury so far? (heat, ice, medications, see a doctor, go to ER?) _____

3. What complaints do you have now? Where is the problem located? _____

4. How bad is the pain? (0=none 10=emergency) Circle one: 1 2 3 4 5 6 7 8 9 10

5. Have you ever injured this area or had the same illness before? Yes No If yes, please describe: _____

6. Please list all medications you are taking for this or any other condition (include OTC meds, periodic injections, drops / sprays, etc...) _____

7. Medication Allergies: (list all medications that you should not take and describe your reaction to them) _____

8. Prior Surgeries: (Please list nature of problem and date of surgery) _____

9. Vaccines: (Check all that apply)

a. Tetanus Booster Date: ____/____/____

b. Hepatitis A 1st dose Date: ____/____/____ 2nd dose Date: ____/____/____

c. Hepatitis B 1st dose Date: ____/____/____ 2nd dose Date: ____/____/____ 3rd dose Date: ____/____/____

d. MMR (measles/mumps/rubella) Had illness Had vaccine Date: ____/____/____

e. Varicella (chickenpox) Had illness Had vaccine Date: ____/____/____

f. Meningococcal Vaccine Date: ____/____/____

g. Last PPD (TB Test) ____/____/____ Result: Negative Positive (Hx. of BCG Vaccine?)

10. Have you ever been told that you have a communicable disease? Yes No If yes, when? _____
What? _____

11. Is English a Second Language? Yes No

12. Please check those which apply: Single Married Divorced Widowed Student

13. Do you smoke or chew tobacco? Yes No How much? _____ packs/day tins/week

14. Do you drink alcoholic beverages? Yes No How much? _____ beers or mixed drinks/week

15. Have you used recreational drugs / substances? Yes No Last used: _____ Drug: _____

16. Hobbies: (Please check all that apply) Weight Lifting Aerobics Hunting Fishing Racing Knitting
 Crochet Needlepoint Internet Surfing Video-games Others _____

17. Family Hx: Father – Age ____ Alive Well Illnesses _____
Mother – Age ____ Alive Well Illnesses _____
Brothers _____
Sisters _____

18. Review of Systems / Previous & Current Medical Problems: (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate / urination problems | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Heart Disease / MI / Surgery | <input type="checkbox"/> Ulcers / Acid Reflux | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Lung Disease /Bronchitis | <input type="checkbox"/> Hearing loss / ringing | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Asthma / Wheezing | <input type="checkbox"/> Balance problems | <input type="checkbox"/> Recent Chest Pain |
| <input type="checkbox"/> Liver Disease / Hepatitis | <input type="checkbox"/> Impaired Coordination | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Kidney Disease / Stones | <input type="checkbox"/> Concussion | <input type="checkbox"/> Bowel Habit Change |
| <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Back Injury / pain | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Neck Injury / whiplash | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Psychosis / Panic Attack | <input type="checkbox"/> Knee pain / arthritis | <input type="checkbox"/> Headaches / Migraine |
| <input type="checkbox"/> Sleep Apnea / impairment | <input type="checkbox"/> Wrist Pain / swelling | <input type="checkbox"/> Asbestos Exposure |
| <input type="checkbox"/> Stroke / paralysis | <input type="checkbox"/> Numbness of fingers | <input type="checkbox"/> Heavy Metal Exposure |
| <input type="checkbox"/> Fainting / Passing Out | <input type="checkbox"/> Weakness of hands / legs | <input type="checkbox"/> Prior Work Comp Injury |
| <input type="checkbox"/> Anemia (low iron) | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Military Service |
| <input type="checkbox"/> Blood Disorders / bleeding | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Are you Pregnant? |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lupus / Connective Tissue Disease | <input type="checkbox"/> Social Security Disability |
| <input type="checkbox"/> (+) HIV test | <input type="checkbox"/> Other arthritis / swelling | <input type="checkbox"/> Other problems |

Provide explanation for all items checked above: _____

I certify that the information provided is accurate and true.

Employee Signature: _____ Date: ____/____/____

19. Physician comments: _____

Physician Signature: _____ Date: ____/____/____

_____/____/____ _____ _____/____/____ _____
Name Date Initial Name Date Initial