



COMPREHENSIVE PATIENT HISTORY FORM
WORKERS' COMPENSATION

NOTE TO OUR PATIENTS: This form will not be provided to the BWC, MCO or employer without your written authorization. Any symptoms or health problems unrelated to your work illness or injury should be addressed by your primary care physician.

Patient Name: _____ Date: _____

Reason for current visit: _____

Personal Physician Information: No Personal Physician/Information Available

Name: _____

Address: _____

Phone #: _____ Fax#: _____

List previous hospitalizations/surgeries/serious injuries:	When/Date?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Marital Status: Single Married Separated Divorced Widowed

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously but quit _____(date) Current: packs/day _____

Use of drugs: Never Type/frequency: _____

Excessive exposure at home or work to: Fumes Dust Solvents Noise

Have you ever had the following?

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis/gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding tendency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acute infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you had any of the following during the past three months? PLEASE ANSWER ALL QUESTIONS!

CONSTITUTIONAL

Good general health lately..... No Yes
 Recent weight change..... No Yes
 Fever..... No Yes
 Fatigue..... No Yes
 Headaches..... No Yes

EYES

Eye disease or injury..... No Yes
 Wear glasses/contact lens..... No Yes
 Blurred or double vision..... No Yes
 Glaucoma..... No Yes

ENT

Hearing loss..... No Yes
 Ringing in the ears..... No Yes
 Earaches or drainage..... No Yes
 Sinus problems..... No Yes
 Nose bleeds..... No Yes
 Mouth sores..... No Yes
 Bleeding gums..... No Yes
 Bad breath or bad taste..... No Yes
 Sore throat or voice change..... No Yes
 Swollen glands in neck..... No Yes

CARDIOVASCULAR

Heart trouble..... No Yes
 Chest pains..... No Yes
 Sudden heart beat changes..... No Yes
 Swelling of feet, ankles or hands..... No Yes

RESPIRATORY

Frequent coughing..... No Yes
 Spitting up blood..... No Yes
 Shortness of breath..... No Yes
 Asthma or wheezing..... No Yes

GASTROINTESTINAL

Loss of appetite..... No Yes
 Change in bowel movements..... No Yes
 Nausea or vomiting..... No Yes
 Frequent diarrhea..... No Yes
 Painful bowel movements or constipation..... No Yes
 Blood in stool..... No Yes
 Stomach pain..... No Yes

GENITOURINARY

Frequent urination..... No Yes
 Burning or painful urination..... No Yes
 Blood in urine..... No Yes
 Change of force of strain when urinating..... No Yes
 Incontinence or dribbling..... No Yes
 Kidney stones..... No Yes
 Sexual difficulty..... No Yes
 Male – testicle pain..... No Yes
 Female – pain with periods..... No Yes
 Female – irregular periods..... No Yes
 Female – vaginal discharge..... No Yes
 Female – # of pregnancies: _____ # of miscarriages: _____
 Female – date of last pap smear: _____
 Female – results of last pap smear: Normal Abnormal

MUSCULOSKELETAL

Joint pain..... No Yes
 Joint stiffness or swelling..... No Yes
 Weakness of muscles or joints..... No Yes
 Muscle pain or cramps..... No Yes
 Back pain..... No Yes
 Cold extremities..... No Yes
 Difficulty in walking..... No Yes

SKIN

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

NEUROLOGICAL

Frequent or recurring headaches..... No Yes
 Light headed or dizzy..... No Yes
 Convulsions or seizures..... No Yes
 Numbness or tingling sensations..... No Yes
 Tremors..... No Yes
 Paralysis..... No Yes
 Stroke..... No Yes
 Head injury..... No Yes

PSYCHIATRIC

Memory loss or confusion..... No Yes
 Nervousness..... No Yes
 Depression..... No Yes
 Sleep problems..... No Yes

ENDOCRINE

Glandular or hormone problem..... No Yes
 Thyroid disease..... No Yes
 Diabetes..... No Yes
 Excessive thirst or urination..... No Yes
 Heat or cold intolerance..... No Yes
 Dry skin..... No Yes
 Change in hat or glove size..... No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts..... No Yes
 Easily bruise or bleed..... No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

ALLERGIC/IMMUNOLOGIC

Known food allergies: _____

I have provided patient instructions related to all changes in home medications for this patient.

 Staff Name/Initials

I give permission to provide a copy of this form to my personal physician and other physicians consulted to treat me for my injury.

Patient's Signature: _____

Date: _____

Significant responses unrelated to the reason for the patient's visit have been reviewed; appropriate follow up with the patient's personal physician(s) has been encouraged.

Physician/Provider's Signature: _____

Date: _____