WASHINGTON HEALTH SYSTEM
Occupational Medicine
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NEW INJURY HISTORY

CONFIDENTIAL – TO REMAIN IN CHART

Name: _____ Birth Date: _____

Employer/Occupation: _____ Date of Injury: _____

Visit #: _____ Today's Date: _____

PLEASE ANSWER ALL QUESTIONS

Chief Complaint:

What is the reason for your visit today?:_____

_____

HPI:

1. How were you injured (*mechanism of injury*)?: _____
   _____
   _____
2. Are you right or left handed (*handedness*)?: _____
3. What is your pain currently on a scale of "0 (no pain) – 10 (worst pain ever)": _____
4. Describe the nature of your pain (*pain quality*): _____
5. What makes your symptoms worsen (*aggravating factors*)?: _____
   _____
6. What makes your symptoms feel better (*alleviating factors*)?: _____
   _____
7. Does your pain radiate anywhere?: _____
8. Are there any factors associated with your injury and/or symptoms (*associated factors*)?: _____
   _____
9. Any prior history of similar type or location of this injury? If so, please explain the circumstances, including treatments, surgeries, etc. (*prior history*): _____
   _____
   _____

Medications:

Please list your **medications**. If you take no medications, check this box ☐ :

_____

_____

_____

Medical History:

1. Do you have any **major medical conditions** such as diabetes, high blood pressure, heart attack, etc.;
   if none, check this box ☐:
   _____
   _____
2. When was your last **Tetanus** booster?: _____
3. Do you have any current work **Restrictions**? ✹ Yes ✹ No

FEMALES ONLY

1. Date of last **menstrual period**: _____
2. Are you currently **breast feeding**?: ✹ Yes ✹ No
3. Are you **pregnant**? ✹ Yes ✹ No

(OVER → →)

Allergies:

List any allergies or intolerances. This includes both Medications and any other substance. If none, check this box □:

_____

_____

Surgical History:

List any past **Surgeries**; if none, check this box □ :

_____

_____

Hospitalizations:

List any past **Hospital Admissions**, dates, why you were there; if none, check this box □ :

_____

_____

Family History:

Any Family History of:

Y N		Y N	
□ □	Cancer	□ □	Lung Disease
□ □	Heart Disease	□ □	Thyroid Disease
□ □	Diabetes	□ □	Carpal Tunnel Syndrome
□ □	High Blood Pressure	□ □	Arthritis
□ □	Back Problems	□ □	Skin Disease

Social History:

	YES	NO	
Do you drink alcohol?	□	□	If so, frequency and amount:
Smoke (now or in the past)?	□	□	If so, frequency and amount:
Take habit forming drugs?	□	□	If yes, what are they:
Treated for drug addiction?	□	□	If yes, when did you complete treatment?
Treated for alcoholism?	□	□	If yes, when did you complete treatment?

ROS:

Are you ***CURRENTLY*** experiencing any of the following symptoms?

- Circle YES answers.
- If NO to all, check this box: ☐.

General/Constitutional:	Chills	Fever	Weight gain or loss that was not planned
Eye:	Double vision	Foreign body sensation	Recent vision changes
Ear, Nose, Mouth, Throat:	Ear drainage / pain	Bloody nose	Sore throat
Cardiovascular:	Chest discomfort / pain	Edema	Palpitations
Respiratory:	Cough	Shortness of breath	Wheezing
Gastrointestinal:	Diarrhea / Vomiting	Liver disease	Stomach ulcers
Genitourinary:	Blood in urine	Kidney disease	Painful urination
Musculoskeletal:	Frequent fractures	Frequent sprains	Arthritis
Skin:	Eczema	Itching	Rash
Neurologic:	Dizziness	Headaches	Seizures
Psychiatric:	Anxiety	Depressed mood	Substance abuse
Endocrine:	Excessive sweating	Decreased energy	Excessive intolerance to cold / heat
Hematology, Immunology:	Easy bleeding / bruising	Lymph node swelling	Severe allergic reaction

_____ _____

Patient Signature Date