INITIAL WORKERS' COMPENSATION MEDICAL REPORT

Name:	Date:
Address:	Age:
City/State/Zip:	Date of Birth:
Phone:	Gender:
Company and Contact:	Job Title:

OCCUPATIONAL HISTORY

Please provide details to any of the following that apply to you:

If you've ever had a work-related injury/illness that caused you to miss more than one day of work.	
Any work restrictions (temporary or permanent) you've ever had.	
Any disabilities that require reasonable accommodations.	

In your job (currently or in the past), please check any of the following you have been exposed to:

- ☐ Asbestos
- ☐ Chemicals
- ☐ Dust (wood, coal, rock, etc.)
- ☐ Extreme heat or cold
- ☐ Lasers
- ☐ Noisy areas
- ☐ Organic Solvents
- ☐ Pesticides
- ☐ Radiation
- ☐ Repetitive use
- ☐ Smoke
- ☐ Vibration (jackhammer)

Please describe any injuries/illness you've experienced because of exposure to the above: ___________________________________

____

Please provide the following details about your current injury or exposure that occurred while at work:

Date:	Location:
In your own words, what happened?	
Body part(s) impacted:	
Which side?	☐ Left ☐ Right
Current limitations:	
Medical treatments tried:	
Pain level (1-10)	

Please rate the following statements from 0 to 10 (0 = not at all, 10 = very well)

How well are you coping with your symptoms? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How supported do you feel by your workplace, coworkers, and managers? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How safe and supported do you feel by your family, friends, and finances? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How confident are you that you will return to your normal work duties? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

PROCEDURES AND IMAGING

Date of last Tdap (tetanus booster): __________

Please check any of the following you are allergic to:

☐ Latex ☐ Iodine ☐ Imaging contrast/dye for CT or MRI

Have you ever experienced claustrophobia (fear of enclosed spaces) in the past?

☐ Yes ☐ No

Do you have metal in your body including shrapnel, bullets, or implanted devices (pacemaker, insulin pump, artificial joints)?

☐ Yes ☐ No

If yes, please explain: ____

MEDICAL HISTORY

Please check any of the following you have been diagnosed with or treated for:

☐ Anemia (low blood)
☐ Arthritis
☐ Asthma/emphysema/COPD
☐ Auto-immune conditions (Lupus, Rheumatoid Arthritis)
☐ Broken bones requiring surgery
☐ Burns
☐ Cancer
☐ Carpal Tunnel Syndrome
☐ Chronic pain
☐ Color blindness
☐ Concussion or head injury
☐ Diabetes (Type 1 or Type 2)
☐ Hearing issues
☐ Heart disease (heart attack, chest pain, heart murmur)
☐ Hernia
☐ Herniated disc
☐ High blood pressure
☐ High cholesterol
☐ HIV
☐ Irregular heartbeat (including pacemaker)
☐ Kidney disease
☐ Liver disease (cirrhosis, hepatitis)
☐ Low back pain
☐ Mental health disorder (anxiety, depression, PTSD)
☐ Migraine or chronic headache
☐ Positive tuberculosis test (TB)
☐ Seasonal allergies
☐ Seizures (convulsions)
☐ Stroke
☐ Tendonitis or bursitis
☐ Other significant illness, disease, or injury

Please explain any that have been checked: ____

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Hospitalizations or surgeries you've had including dates: ____

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Are you currently pregnant? ☐ Yes ☐ No

If so, please indicate how far along you are (gestational age): ____________

Are you currently breastfeeding? ☐ Yes ☐ No

Please list medications including prescription and over-the-counter vitamins and herbal supplements: ______________________

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Please list any allergies to medications: ____

Do you drink alcohol? ☐ Yes ☐ No

If yes, average number of drinks per day? ____________

I certify that all information contained in this personal medical history is true. I agree that any misleading or false statements may render my employment application void and would be sufficient cause for immediate dismissal in the event of employment. I understand that this health assessment does not duplicate or replace the actual physical done by my physician. I understand that in the event of a work-related injury, pertinent medical information acquired during the post-offer evaluation or employee's health record may be released to the organization's industrial insurance or emergency medical providers.

Patient Signature______________________________________ Date: ______________________