FreedomUrgentCare

SETON MEDICAL CENTER HARKER HEIGHTS

OCCUPATIONAL ACCIDENT-INJURY HISTORY

NAME:____ TODAYS DATE: ___________________________

Date of Injury: ____________________What part of your body was injured? ____

Describe how you injury/illness/accident occurred? ____

Yes No 1. Have you ever been treated for the same body part and/or injury? If yes, when? __________________________

Yes No 2. Do you have any allergies? If yes, list ____
____

Yes No 3. Are you taking ANY medications? If yes list (include ALL over the counter meds) _______________________
____

Yes No 4. Have you ever been hospitalized and/or had surgery? If yes, list year and reason __________________________
____

Yes No 5. Have you ever had any broken bones? If yes, list ____

DATE OF LAST TETANUS ___________________________________

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Have you or a member of your immediate family (mother, father, sibling) ever been diagnosed with: (Please check)

Condition	Self	Family		Self	Family
Fatigue, insomnia or weakness			Eczema or skin allergies		
Ear, Nose, throat or vision problems			Head injuries		
High blood pressure			Epilepsy or seizures		
Heart attack, chest pain or stroke			Dizziness, blackouts, or fainting		
Heart problems or irregular heart beat			Anxiety, depression, or mental disorders		
Lung problems, asthma, bronchitis			Frequent Headaches		
Tuberculosis or positive TB test			Drug or alcohol abuse		
Emphysema or chronic cough			Arthritis		
Ulcers, intestinal, or stomach problems			Shoulder, arm or wrist problems		
Liver or spleen problems			Carpal tunnel syndrome		
Kidney or urinary problems			Back or neck problems		
Hernias			Leg, ankle, foot or knee problems		
Diabetes or thyroid disease			Gout		
Cancer			Exposure to hazardous substances		
Bleeding disorders			Any other medical condition not listed above		

I acknowledge that I have read, understand, and answered all questions truthfully.

Signature: ____ Date: ______________________________

MD/PA/NP, please review and sign. Make any additional comments: ____
____

Provider Signature: ____Date: ______________________________