Acadiana Center for Orthopedic and Occupational Medicine
2501 West Pinhook Road; Lafayette, LA 70508; Phone (337) 269-0136; Fax (337) 233-8525

History & Physical Examination

Name _____ **SSN** _____ **Date of Birth** _____

Company _____ **Job Title**_____ **Sex** ☐ **Male** ☐ **Female**

MEDICAL/SURGICAL HISTORY

Do you have a HISTORY of any of the following medical problems and/or CURRENT complaints?

Yes	No		Yes	No		Yes	No		Yes	No	
__	__	Cancer	__	__	Heart Murmur/Gallop	__	__	Current Fever/Chills	__	__	Cough/Bronchitis/Pneumonia
__	__	Seasonal Allergies	__	__	Pacemaker/Defibrillator	__	__	Sleep Disorder/Apnea	__	__	Wheezing/Asthma
__	__	Hives/Flushing	__	__	Cholesterol/Lipids	__	__	CPAP/Bi-PAP	__	__	COPD/Emphysema
__	__	Corrective Lens	__	__	Bypasses and/or Stents	__	__	Insomnia/Restless Legs	__	__	Tuberculosis/Positive PPD
__	__	Cataracts	__	__	Heart Valve Problems	__	__	Narcolepsy	__	__	Sinus/Nasal Problems
__	__	Glaucoma	__	__	Hemorrhoids/Fissures	__	__	Light Headed/Fainting	__	__	Bleeding/Clots/Anemia
__	__	Rash/Sores/Hives	__	__	Bariatric Surgery	__	__	Disabling Headaches	__	__	Nerve Damage/Burns
__	__	Staph Infections	__	__	Current Diarrhea	__	__	Motion Sickness	__	__	Limps/Braces/Prostheses
__	__	Dermatitis/Eczema	__	__	Gallbladder Problems	__	__	TIA/Stroke/Dementia	__	__	Hearing Loss/Aids/Ringing
__	__	Psoriasis/Plaques	__	__	Pancreas/Spleen Disease	__	__	Epilepsy/Seizures/Fits	__	__	Carpal Tunnel or Tarsal Tunnel
__	__	Dental Problems	__	__	Jaundice/Yellow Eyes	__	__	Post-Traumatic Stress	__	__	Pain in Arms and/or Legs
__	__	Dentures/Implants	__	__	Liver Disease/Hepatitis	__	__	Dizziness/Vertigo	__	__	Weak in Arms and/or Legs
__	__	Diabetes	__	__	Ulcer/Reflux Problems	__	__	Anger Problems	__	__	Back/Neck Stiffness or Pain
__	__	Insulin Use	__	__	Groin/Abdomen Hernia	__	__	Nervous/Anxiety	__	__	Joint Stiffness/Pain/Swelling
__	__	Thyroid Disease	__	__	Colitis/Crohn's Disease	__	__	Panic Attacks	__	__	Numbness/Tingling
__	__	Heart Disease	__	__	Blood in Urine or Stool	__	__	Bipolar Disorder	__	__	Decreased Range of Motion
__	__	Chest Pain/Angina	__	__	Bladder Disease/Infection	__	__	Depression	__	__	Broken Bones/Dislocations
__	__	MI/Heart Attack	__	__	Kidney Disease/Stones	__	__	EVER Suicidal	__	__	Rheumatoid/Osteo Arthritis
__	__	Heart Failure	__	__	Prostate Disease	__	__	ADD/ADHD	__	__	Fibromyalgia/Rheumatism
__	__	Blood Pressure	__	__	Pregnancy/Recent Births	__	__	Schizophrenia/Psychosis	__	__	Other Diagnosis/Complaint
__	__	Rhythm Problems	Last Menstrual Period_____			__	__	Alcohol/Drug Treatment	Specify_____		

Yes	No	
__	__	Have you ever had any injuries/surgeries to your neck and/or back? **If yes, explain:** _____
__	__	Have you ever had any injuries/surgeries to your shoulder, elbow, wrist, hand, fingers and/or arm? **If yes, explain:** _____
__	__	Have you ever had any injuries/surgeries to your hip, knee, ankle, foot, toes and/or leg? **If yes, explain:** _____
__	__	Have you had any other injuries requiring medical/surgical attention? **If yes, explain:** _____
__	__	Do you use any routine medication? (Prescribed or Over the Counter) **If yes, list:** _____
__	__	Are you allergic to any medication? **If yes, list medication & reaction:** _____
__	__	Have you ever received outpatient and/or hospitalization for mental health problems? **If yes, explain:** _____
__	__	Have you ever had any other surgical procedures? **If yes, explain:** _____

SOCIAL/OCCUPATIONAL HISTORY

Yes	No	
__	__	Do you use tobacco products? **If yes, what type? How much**? _____
__	__	Do you drink alcohol? **If yes, what type & how much in an average week**? _____
__	__	Have you EVER had an illness, injury, or claim arising out of your employment? **If yes, explain:** _____
__	__	Have you EVER been removed from work due to a sensitivity to chemicals/fumes? **If yes, explain:** _____
__	__	Are you collecting any payments for temporary, partial, or total disability from the military, social security, or other agency?

NOTICE **FAILURE TO ANSWER THE ABOVE QUESTIONS TRUTHFULLY MAY RESULT IN FORFEITURE OF WORKERS COMPENSATION BENEFITS, MAY ALTER THE MEDICAL ASSESSMENT AND RECOMMENDATION, AND MAY RESULT IN THE WITHDRAWL OF EMPLOYMENT OFFER OR LEAD TO TERMINATION BY THE EMPLOYER.**

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

Patient Signature **Date**

MEDICAL PROVIDER HISTORY REVIEW & COMMENTS **Patient Name** _____

_____

_____

_____

_____

_____

_____

_____

	Normal	Abnormal
General	_____	_____
Skin	_____	_____
Neck/Scar	_____	_____
ROM	_____	_____
HEENT	_____	_____
Chest	_____	_____
Heart	_____	_____
Lungs	_____	_____
Abdomen	_____	_____
Genitals	_____	_____
Hernias	_____	_____
Extremities	_____	_____
ROM	_____	_____
Neurological	_____	_____
Back/Scar	_____	_____
Mental Status	_____	_____

Frame ☐S ☐M ☐L

Dominant Hand ☐ Right ☐ Left

Interpreter Initials _____

Chaperone Initials _____

HT_____ **WT**_____ **BMI**_____ **BP**_____ **HR**_____ **Temp**_____

VISION

	Uncorrected	Corrected ☐Glasses ☐Contacts
DISTANCE	Right 20/_____ Left 20/_____	Right 20/_____ Left 20/_____
	Both 20/_____	Both 20/_____
		Corrected ☐**Glasses** ☐**Contacts**
NEAR	Right 20/_____ Left 20/_____	Right 20/_____ Left 20/_____

COLOR ☐Normal ☐Abnormal ☐ Ishihara ☐Machine _____ Out of _____
Patient Can Recognize Colors ☐ Yes ☐ No

DEPTH ☐Normal ☐ Abnormal ☐Machine _____ Out of _____

PERIPHERAL Right_____ Degrees Left_____ Degrees ☐ Confrontation Normal

OTHER _____

HEARING ☐Audiometer Testing ☐ Normal ☐ Abnormal
☐ Conversational Hearing Acceptable ☐ Yes ☐ No
☐ Tested with Hearing Aid ☐ R ☐ L ☐ Both

URINE DIP Specific Gravity_____ Albumin_____ Glucose_____

Blood _____ Nitrate _____ Other _____

Abnormalities _____

BLOOD HgbA1c_____% Glucose_____ ☐ Fast ☐ Non-Fast

MEDICAL PROVIDER ASSESSMENT & COMMENTS

_____

_____

_____

_____

_____

Signature of Provider _____

☐G. Gidman, MD ☐C. Hernandez, MD ☐F. Baniewicz, Jr., MD ☐A. O'Quin, ANP ☐K. Knecht, ANP ☐R. Haylik, FNP