2501 West Pinhook Road ♦ Lafayette, LA 70508
Phone (337)269-0136 ♦ Fax (337)233-8525

WORKER COMPENSATION INJURY FORM

(Patient to complete all shaded areas)

Name: ______ **SSN:** ______ **Case Number:** ______

Date of Injury: ______ **What part of body was injured?** ______

Describe how injury/illness occurred: ______

Have you ever been treated for the same body part and/or injury? ☐ **YES** ☐ **NO** **If yes, When** ______

Do you have any allergies? ☐ **YES** ☐ **NO** **If yes, List:** ______

Are you currently taking ANY medication? ☐ **YES** ☐ **NO** **If yes, List (include over the counter and herbal meds):**

______

Have you ever been hospitalized and/or had surgery? ☐ **YES** ☐ **NO** **If yes, List year and reason:**

______

Have you ever had any broken bones? ☐ YES ☐ NO If yes, List: ______

Date of last Tetanus Injection ______ Are you pregnant? ☐ YES ☐ NO Date of last menstrual period: ______

DO YOU CURRENTLY HAVE OR HAVE YOU EVER BEEN TOLD YOU HAVE : (check box next to all that apply)

1. Fatigue, insomnia or weakness ☐
2. Ear, nose, throat or vision problems ☐
3. High Blood Pressure ☐
4. Heart attack, chest pain, or stroke ☐
5. Heart problems or irregular heart beat ☐
6. Lung problems, asthma, bronchitis or pneumonia ☐
7. Tuberculosis or postive skin test ☐
8. Emphysema or chronic cough ☐
9. Ulcers, intestinal, abdominal or stomach problems ☐
10. Liver or spleen problems ☐
11. Kidney or urinary problems ☐
12. Hernia ☐
13. Diabetes or thyroid problems ☐
14. Cancer ☐
15. Bleeding disorders ☐
16. Eczema or Allergies ☐
17. Head injuries ☐
18. Epilepsy or seizures ☐
19. Dizziness, blackouts, or fainting ☐
20. Anxiety, depression, mental disorders ☐
21. Frequent headaches ☐
22. Drug, and/or alcohol abuse ☐
23. Arthritis ☐
24. Shoulder, arm or wrist problems ☐
25. Back or neck problems ☐
26. Carpal tunnel syndrome ☐
27. Leg, ankle, foot or knee problems ☐
28. Gout ☐
29. Exposure to hazardous materials ☐
30. Any othe medical condition not listed, provide in box below ☐

______

• *Check YES or NO for the following questions. If yes, explain in the blank provided.*

Has any of your immediate family (**mother, father, sibling**) ever been told they had the same above conditions? ☐ **YES** ☐ **NO**
If yes, please list number of item(s) and explain who and what condition.

______

Do you drink alcohol? ☐ **YES** ☐ **NO** **If yes,** how many drinks per day: ______

Do you smoke/use tobacco products? ☐ **YES** ☐ **NO** **If yes,** what kind? (cigarettes, chewing tobacco) : ______

How many packs per day: ______ **If you have ever smoked, when did you stop?** ______

NOTICE: YOUR FAILURE TO ANSWER TRUTHFULLY ANY QUESTIONS ABOUT PREVIOUS INJURIES, DISABILITIES, OR MEDICAL CONDTIONS MAY RESULT IN FORFEITURE OF WORKER'S COMPENSATION BENEFITS UNDER LSA R.S. 23:1208.1.

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

Patient Signature: ______ **Date:** ______

Physician Signature:______________________ **Date:**______________