ACADIANA CENTER

2501 W. Pinhook Road ♦ Lafayette, LA 70508
Phone 337-269-0136 ♦ Fax 337-233-8525

# OCCUPATIONAL MEDICINE: HISTORY & PHYSICAL EXAMINATION

(Patient to complete all shaded areas)

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

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

## *MEDICAL/SURGICAL HISTORY*

***Do you have a HISTORY of any of the following medical problems and/or CURRENT complaints?*** *(check all that apply)*

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | 1. Seasonal Allergies/Sinusitis | ☐ | ☐ | 18. Sleep Apnea/Sleep Disorder | ☐ | ☐ | 35. Pregnancy |
| ☐ | ☐ | 2. Hives/Flushing/Rash | ☐ | ☐ | 19. CPAP/BIPAP | ☐ | ☐ | 36. Anemia/Bleeding Disorder |
| ☐ | ☐ | 3. Cataracts/Glaucoma | ☐ | ☐ | 20. Tuberculosis/Other Lung Disease | ☐ | ☐ | 37. Broken Bones/Dislocations/Fractures |
| ☐ | ☐ | 4. Dental Problems | ☐ | ☐ | 21. Heart Attack | ☐ | ☐ | 38. Amputations |
| ☐ | ☐ | 5. Skin Conditions | ☐ | ☐ | 22. Chest Pain/Angina | ☐ | ☐ | 39. Arthritis/Joint Pain |
| ☐ | ☐ | 6. Staph Infections | ☐ | ☐ | 23. Heart Failure/Valve Problem/Murmur | ☐ | ☐ | 40. Back or Neck Injuries |
| ☐ | ☐ | 7. Burns | ☐ | ☐ | 24. Heart Rhythm Problem | ☐ | ☐ | 41. Numbness/Tingling/Nerve Problems |
| ☐ | ☐ | 8. Cancer | ☐ | ☐ | 25. High Blood Pressure | ☐ | ☐ | 42. Carpal Tunnel/Tarsal Tunnel |
| ☐ | ☐ | 9. Diabetes | ☐ | ☐ | 26. High Cholesterol | ☐ | ☐ | 43. Anxiety/Depression |
| ☐ | ☐ | 10. Thyroid Disease | ☐ | ☐ | 27. Pacemaker/Stent | ☐ | ☐ | 44. Bipolar/Schizophrenia |
| ☐ | ☐ | 11. Head Injury | ☐ | ☐ | 28. Gallbladder/Pancreas/ Spleen Disease | ☐ | ☐ | 45. ADD/ADHD |
| ☐ | ☐ | 12. TIA/Stroke | ☐ | ☐ | 29. Liver Disease/Jaundice | ☐ | ☐ | 46. Post Traumatic Stress |
| ☐ | ☐ | 13. Epilepsy/Seizures | ☐ | ☐ | 30. Gastric Reflux/Stomach Ulcer | ☐ | ☐ | 47. Addiction to Alcohol or Drugs |
| ☐ | ☐ | 14. Migraine Headaches | ☐ | ☐ | 31. Colitis/Crohn's Disease | ☐ | ☐ | 48. Addition or Mental Health Treatment |
| ☐ | ☐ | 15. Narcolepsy | ☐ | ☐ | 32. Hernia | ☐ | ☐ | 49. Smoke or Use Tobacco |
| ☐ | ☐ | 16. Dizziness/Vertigo | ☐ | ☐ | 33. Kidney/Bladder Disease | ☐ | ☐ | 50. Any Illness or Injury not listed above: |
| ☐ | ☐ | 17. Asthma/COPD/Emphysema | ☐ | ☐ | 34. Prostate Disease | ☐ | ☐ | |

If you answered YES to any of the above conditions, list the number and provide details:

List any past surgeries:

List any injuries that required medical or surgical attention:

List your current medications, including any over the counter medicines:

List any allergies to medications:

List any work related injuries or diseases:

Have you EVER filed a Worker's Compensation Claim?
If Yes, provide dates of claim, nature of the claims, and outcomes:

*****FAILURE TO ANSWER THE ABOVE QUESTIONS TRUTHFULLY MAY RESULT IN FORFEITURE OF WORKERS COMPENSATION BENEFITS**

***I have read the above statement and the answers to the above questions. I certify them to be true and correct.***

**Patient Signature** _____ **Date** _____