



TOTAL OCCUPATIONAL MEDICINE • A DIVISION OF CONVENIENT CARE, LLC

Name SSN Date of Birth
Address City State ZIP
Telephone () COMPANY Job Title

I. MEDICAL HISTORY- Please answer every question.

A. Have you ever had: YES NO YES NO YES NO YES NO
1. Cancer 12. Schizophrenia 23. Emphysema 34. Back trouble
2. Allergies 13. Depression 24. High blood pressure 35. Urinary bladder trouble
3. Hay fever 14. Bipolar disorder 25. Heart murmur 36. Kidney trouble
4. Hives 15. Anxiety attacks 26. Hepatitis 37. Prostate trouble
5. Poor vision 16. Atopic dermatitis 27. Peptic ulcer 38. Migraine headaches
6. Glaucoma 17. Psoriasis 28. Colitis 39. Epilepsy
7. False Teeth 18. Fungal infection 29. Hemorrhoids 40. Stroke
8. Rhinitis 19. Yeast infection 30. Hernia 41. Motion sickness
9. Broken bone 20. Tuberculosis 31. Arthritis 42. Sea sickness
10. Diabetes 21. Chronic bronchitis 32. Pancreatic disease 43. Other illness
11. Thyroid trouble 22. Asthma 33. Ruptured disc

B. Do you now have: YES NO YES NO YES NO YES NO
1. Fever 12. Frequent headaches 23. Skin sores 34. Blood in stool
2. Tire easily 13. Numbness 24. Productive cough 35. Dark urine
3. Weight loss 14. Tingling anywhere 25. Dry cough 36. Burning on urination
4. Flushing 15. Fits / seizures 26. Chest pain 37. Wake up at night to urinate
5. Frequent infections 16. Tremors 27. Wheezing 38. Leg pain from walking
6. Runny nose 17. Dizziness 28. Shortness of breath 39. Weak in arms or legs
7. Sore throat 18. Get angry easily 29. Wake up short of breath 40. Back pain
8. Light headedness 19. Nervousness 30. Nausea and vomiting 41. Joint stiffness
9. Swelling around eyes 20. Depression 31. Loose stools 42. Trouble sleeping
10. Eye trouble 21. Rash 32. Yellow eyes
11. Bags under eyes 22. Itching 33. Abdominal pain
FEMALES ONLY:
Date of last menstrual period

C. Are you allergic to any medication? If yes list
D. Do you take routine medication; prescription or over the counter?
E. Have you ever had any low back injuries or trouble with your low back?
F. Have you ever had any other major injury?
G. Have you ever had surgery to your back, knee, shoulder, elbow, hand or ankle? (please circle area)
H. Have you had any other surgery? Please list
I. Please give the approximate year that you last received a tetanus injection.
II. SOCIAL HISTORY
A. Do you use tobacco or tobacco products? If yes, what type and how much?
B. Do you drink alcohol? If yes, how much per week?
III. OCCUPATIONAL HISTORY
A. Are you capable of frequently lifting 100 pounds? If NO, how much can you lift?
B. Have you ever had an injury or illness arising out of your employment?
C. Have you ever had any sensitivity, become ill, or been removed from work from being around chemicals, fumes, sunlight, or dust?
D. Have you ever been exposed to asbestos?
E. What is your usual occupation / trade?
F. How many pounds were you required to lift on your last job?

NOTICE : YOUR FAILURE TO ANSWER TRUTHFULLY ANY QUESTIONS ABOUT PREVIOUS INJURIES, DISABILITIES OR OTHER MEDICAL CONDITIONS MAY RESULT IN FORFEITURE OF WORKERS COMPENSATION BENEFITS UNDER LSA R.S. 23:1208.1.
I acknowledge that I have answered all questions truthfully and I have read and understood the above NOTICE

SIGNATURE DATE

