PROMPT CARE & LAWRENCE OCCUPATIONAL HEALTH

Patient Name:_____Date of Birth:_____Anatomical Sex: M F
Gender Identity:_____ Age:_____ Best Phone#:_____ Detailed Messages ok? Y N
Dominant Hand: R L Approximate Height:_____Approximate Weight:_____ Currently Pregnant: Y N ?
Preferred Pharmacy:_____ Primary Care Physician:_____
Please list all medications you are currently taking or circle None:_____
_____
List any allergies to medications/foods or circle None: _____

MEDICAL HISTORY do you/have you had, if YES please give details:

Yes	No		Yes	No	
___	___	Arthritis_____	___	___	Kidney Problems_____
___	___	Gout_____	___	___	Hepatitis/Liver Disease_____
___	___	Anemia_____	___	___	Gall Bladder Disease_____
___	___	Tendency to Bleed_____	___	___	Asthma_____
___	___	Blood Clots_____	___	___	COPD/Emphysema_____
___	___	Cancer_____	___	___	Sleep Apnea_____
___	___	Diabetes_____	___	___	Tuberculosis_____
___	___	Ear, Nose & Throat Problems_____	___	___	Freq. Pneumonia/Bronchitis_____
___	___	Seasonal Allergies_____	___	___	Chronic Pain, Where:_____
___	___	Stomach Ulcer_____	___	___	Dementia/Alzheimer's_____
___	___	GERD/Reflux_____	___	___	Frequent Headaches_____
___	___	Irritable Bowel_____	___	___	Head Injury/Concussion_____
___	___	Hemorrhoids/Rectal Problems_____	___	___	Epilepsy/Seizures_____
___	___	Diverticulitis/losis_____	___	___	Neuropathy_____
___	___	Hernia_____	___	___	Stroke/TIA_____
___	___	Urinary Problems_____	___	___	Depression/Anxiety_____
___	___	Prostate Problems_____	___	___	Other Mental Health_____
___	___	Heart Attack_____	___	___	Substance Abuse_____
___	___	Coronary Artery Disease_____	___	___	STDs_____
___	___	Heart Murmur_____	___	___	Skin Problems_____
___	___	Abnormal Heartbeat_____	___	___	Thyroid Problems_____
___	___	Other Heart Conditions_____	___	___	Special/Restricted Diet_____
___	___	High Blood Pressure_____	___	___	Corrective Lenses or Hearing Aids_____
___	___	High Cholesterol_____	___	___	Other_____

1. Any history of pain lasting more than 3 months or injury to Shoulders, Arms, Elbows, Wrist, Hands, Fingers: _____
2. Any history of pain lasting more than 3 months or injury to Hips, Legs, Knees, Ankles, Feet, Toes:_____
   _____
3. Any history of pain lasting more than 3 months or injury to Chest, Ribs, Abdomen, Pelvis: _____
   _____
4. Any History of pain lasting more than 1 month or injury to Neck, Back, Spine: _____
   If yes, any Spine Fractures, Back Surgeries, Pain or Tingling Radiating to other body parts: _____
5. Please list ALL past Surgeries: _____
   _____
6. Do you smoke, chew or vape, if YES how much:_____ How often do you exercise?_____
7. Do you use alcohol, if YES how much:_____ Do you use any street/unprescribed Drugs?_____
8. Any close blood relatives with: Cancer_____ Heart Problems_____ Diabetes_____ Other_____
9. Is your preventive health up to date: Y N ? Last Tetanus Shot Date:_____ Flu Shot this year: Y N ?
10. Any history of working in hazardous areas such as Foundry, Mine, Quarry, Textile Mill, Asbestos, Solvents, Chemicals, Sandblasting, Smoke, Gas, Dust, Fumes, Radiation?_____
11. Do you have any physical or mental problems that interfere with work, daily living or activity, and/or has a medical provider recommended any restrictions on your activity?_____

I certify that all the information given herein is correct and complete to the best of my knowledge and belief.

Signature_____ **Print**_____ **Date**_____