Date:_____ **PATIENT HISTORY** Thomas Youm, MD

WORKER'S COMPENSATION

RYC Orthopaedics, PC

Name_____ Employer_____
Address_____ Address_____
_____ _____
Phone(H)_____ DOB_____ SS#_____
(W)_____Age_____ Requesting Doctor:_____
Insurance_____ Address_____
WCB#_____ Phone_____
CC#_____ Other Referral:_____

Initial Visit Date_____ Occupation_____
Age_____ Height_____ Weight_____ *Handed:* R L
Eyes_____ Hair_____ *Sex:* M F *Race:* W_____B_____Asian_____Hisp_____

History Present Illness *(what happened?)* ***Date of Accident:_____***

What are your present complaints?_____
_____

How did your injury occur? (brief description of accident)_____
_____
_____

Were you injured by a motor vehicle? YES NO
Was the accident reported to your employer? YES NO
Where did you receive initial treatment?
Name of Doctor/Hospital_____ Date_____
Were you taken by: AMBULANCE CAR WALK
Xrays taken: YES NO AREA:_____
Were you treated by another doctor? YES NO Name_____
Were there any operations for this condition? YES NO
Date of operation_____ Name of Hospital_____
Type of operation_____
Any cast for this condition? YES NO What part of the body_____
How big was the cast_____ How long did you wear the cast_____
What treatments have you tried? Nothing__ Medications(specify)_____
PT_____ Injections(specify)_____Other_____
Improvement with treatment? Which? _____

Studies? *Xrays* _____*MRI*_____ *CT Scan*_____ *EMG*_____ *Other*_____

(When? Results?)_____

Are you presently working? YES NO

If not working, when was the last day you worked?_____

Review of Systems: Have you had any of the following recently?

Fever or Chills_____ Blurred Vision_____ Shortness of Breath_____ Sore Throat_____

Chest Pain_____ Nausea_____ Painful Urination_____ Rashes_____ Headaches_____

If so, explain:_____

Allergies_____***Tolerate NSAIDs***? _____

Social Hx: Tobacco___ Alcohol___ Drugs___ ***Pregnant***: Y N ***Marital Status***: S M D W

Family History: DIABETES HEART DISEASE CANCER HYPERTENSION STROKE

If parent(s) deceased, underlying condition? Mother_____ Father_____

Medical Hx: HEART LUNGS STOMACH LIVER KIDNEY BLADDER DIABETES HTN

Explain:_____

_____

Prior Surgeries_____

_____

_____

Medications_____

_____

_____

Are you taking blood thinners: COUMADIN ASPIRIN PLAVIX _____

*Signature of Patient*_____ *Date*_____

Notes:

*Signature of Doctor*_____ *Date*_____