HONORHEALTH

New Injury History

☐ Thompson Peak
20401 N. 73rd St., Ste. 255
Scottsdale, AZ 85255
Phone: (480)323-1880
Fax: (480) 905-1136
Hours: 7:30am-5:00pm

☐ Osborn
3501 N. Scottsdale Rd. Ste 231
Scottsdale, AZ 85251
Phone: (480) 882-4770
Fax: (480) 882-4391
Hours: 7:30am-5:00pm

☐ Shea
10200 N. 92ND St. Ste 102
Scottsdale, AZ 85258
Phone: (480) 323-3818
Fax: (480) 323-3238
Hours: 7:30am-5:00pm

☐ Deer Valley
19841 N. 27th Ave, Ste. 200
Phoenix, AZ 85027
Phone: (623) 879-5499
Fax: (623) 879-1550
Hours: 7:30am-4:00pm

☐ North Mountain
9225 N. 3rd St., Ste. 103
Phoenix, AZ 85020
Phone: (602) 906-3510
Fax: (602) 906-3511
Hours: 7:30am-4:00pm

Name – Last	First	M.I.	Age	Date of Birth	Social Security #

Address	City	State	Zip	Phone
				( )

Personal Healthcare Provider - Name	Address	Phone
		( )

Emergency Data - Name & Relationship	Address	Phone
		( )

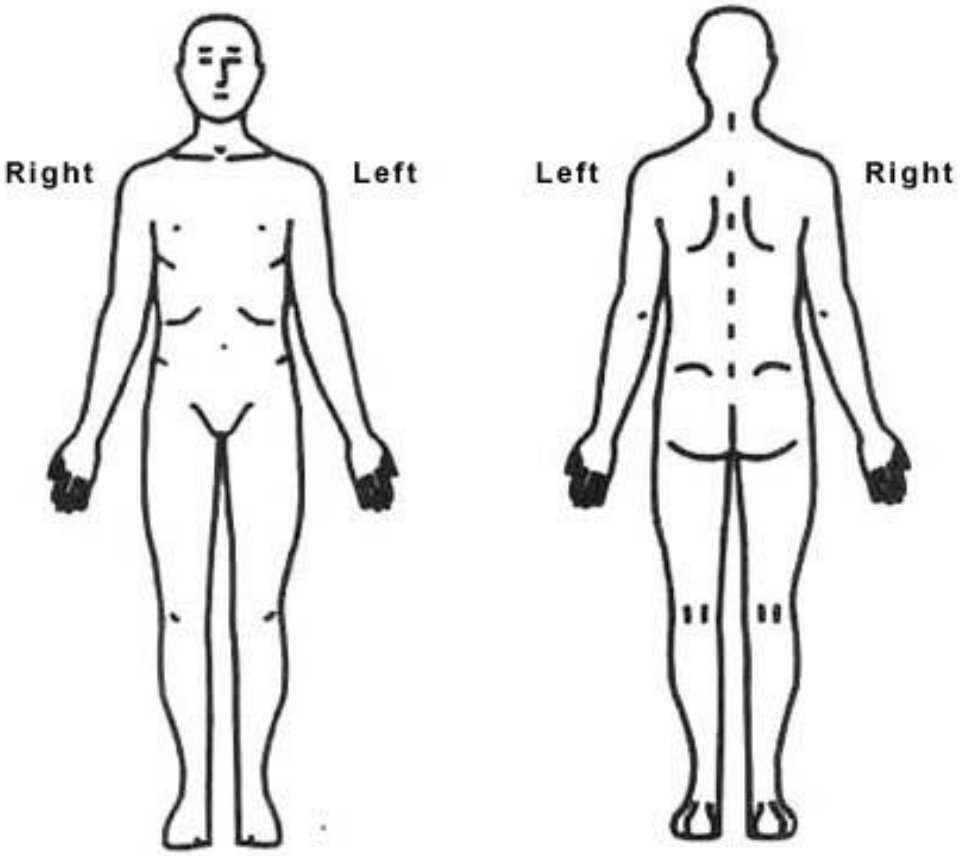
Employment Data - Company Name	Address

Department	Job Title	Name of Supervisor	Phone
			( )

Date of injury: _____Describe how you were injured:_____
_____
_____

DRAW WHERE YOUR PAIN OR YOUR INJURY IS: (YOU CAN USE THESE SYMBOLS)

Ache ^^^^ Stabbing ///// cramping ##### numbness ==== burning xxxxx, other OOOO (describe)



How bad are your symptoms today?

0	1	2	3	4	5	6	7	8	9	10
None		mild	moderate		bad		severe		worst possible	

Have you ever had any similar pain or injuries? _____
What is your current job? _____ Full time or part time?_____
How long have you performed this job?_____ Are you right or left handed? (circle)_____
Are you being treated anywhere else for this injury? Yes/No? If yes, where? _____

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Work History

Yes	*No*	
☐	☐	Have you had any other job related injury or illness? If yes are you being treated for it or do you have any restrictions from it?_____
☐	☐	Have you served in the military? If yes, do you have any disability rating? _____
☐	☐	Do you have another job or go to school? _____

Review of Symptoms

Circle any of these symptoms you are having and explain them below:

Constitutional symptoms **NONE** ☐	Unexplained weight loss, night sweats, fatigue/malaise/lethargy, sleeping pattern, appetite, fever, itch/rash, recent trauma, lumps/bumps/masses
Eyes **NONE** ☐	Visual changes, blurry vision, eye pain, double vision, (blind spots), floaters, eye drainage, contact lenses, glasses
Ears, nose, mouth, and throat (ENT) **NONE** ☐	Runny nose, frequent nose bleeds, sinus pain, stuffy ears, ear pain, ringing in ears (tinnitus), toothache, sore throat, pain with swallowing, hoarseness
Cardiovascular **NONE** ☐	Chest pain, shortness of breath, exercise intolerance, edema, palpitations (skipped beats, racing heart), faintness, loss of consciousness, leg pain with walking, swollen legs, blood clots
Respiratory **NONE** ☐	Cough, sputum, wheeze, shortness of breath, exercise intolerance, wheezing, positive TB test, snoring, excessive daytime sleepiness, sleep apnea
Gastrointestinal **NONE** ☐	Abdominal pain, difficulty swallowing (solids vs liquids), indigestion, bloating, cramping, nausea/vomiting, diarrhea/constipation, , vomiting blood, bright red blood per rectum, dark black tarry stools, change in bowel habits
Genitourinary **NONE** ☐	Incontinence (full loss of bladder control), dribbling with cough or sneeze, pain with urination, decreased urination, decreased force of stream
Musculoskeletal **NONE** ☐	Pain, morning stiffness, joint swelling, decreased range of motion, functional deficit, arthritis, back pain, fractures, sprains, hypermobility
Skin **NONE** ☐	Rashes, itching, wounds, eczema, excessive dryness and/or discoloration, easy bruising
Neurological **NONE** ☐	Changes in sight, smell, hearing and taste, seizures, faints, headache, pins and needles or numbness, limb weakness, poor balance, speech problems, confusion, sleepiness, memory loss, head injury, concussion
Psychiatric **NONE** ☐	Depression, abnormal sleep patterns, anxiety, difficulty concentrating, mood changes
Endocrine **NONE** ☐	Weight loss or gain with normal appetite, tremor, palpitations, hypothyroid, weight gain, Diabetes: increased thirst or urination, dizziness, sweating, headache, hunger
Blood and lymphatic **NONE** ☐	Anemia, prolonged or excessive bleeding, use of anticoagulant and antiplatelet drugs (including aspirin),
Allergic/immunologic **NONE** ☐	"Difficulty breathing" or "choking" (anaphylaxis) as a result of exposure to anything, allergic response (rash/itch) to materials, foods, animals, reaction to bee sting, runny nose or itchy/teary eyes; foods.

Explain or other not listed:

_____

_____

FEMALES: Are you pregnant? Yes/No When was your last period? _____

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Occupational History

Have you been exposed to any of these at home or work?

Yes	No		Yes	No	
☐	☐	Asbestos	☐	☐	Loud Noise
☐	☐	Dust	☐	☐	Solvents/Chemicals
☐	☐	Extreme Heat/Cold	☐	☐	Vapors/Gases
☐	☐	Infectious Agents	☐	☐	Vibration

Past Medical/ Social /Family History

☐ ☐ Do you have any current medical problems (Diabetes, hypertension, GERD, arthritis, etc.)? If yes, list:

_____ _____ _____ _____

_____ _____ _____ _____

☐ ☐ Have you ever had a reaction, allergy and/or sensitivity to drugs, food, plants, animals, latex gloves or any other substance? If yes, complete list below:

Medication/Substance and reaction

_____ _____ _____ _____

☐ ☐ Do you currently take medications (include supplements and over the counter)? If yes, list medication and condition for treatment:

Medication	*Condition*	*Medication*	*Condition*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ ☐ Have you had inpatient or outpatient operations/injuries/Illnesses? If yes, complete list below:

Date	*Operation/Injury/Illness*
_____	_____
_____	_____
_____	_____

☐ ☐ Do you use tobacco? If yes: Type: _____ number per day:_____ e cigs _____

How many times per week do you use alcohol? _____ how much? _____

Comments: _____

_____

Immunizations

Yes	No		Date	Yes	No		Date
☐	☐	Hepatitis B (1,2,3,titer)	_____	☐	☐	Tetanus	_____
☐	☐	Measles	_____	☐	☐	TB Skin Test	_____
☐	☐	Mumps	_____	☐	☐	Reaction to TB Skin Test. If yes, explain	_____
☐	☐	Rubella	_____	☐	☐	Other, describe:	_____

Family History

Yes	No	
☐	☐	Do you have any relevant family history? (bleeding or clotting disorders, immune disorders like rheumatoid arthritis, osteoarthritis, diabetes, cancer?)

_____

Advance Directives

Yes	No	
☐	☐	Do you have Advance Directives? Advance Directives presented at subsequent visits will be entered into your medical record and will be followed.

I hereby certify that the information contained in this health questionnaire is true and correct. Any omission or misrepresentation of facts may be a basis for disciplinary action pending employer's policy or denial of industrial claim if for a worker's compensation injury.

_____ _____

Signature Date

NURSE: HT_____ WT _____BMI:_____ T: _____ P: _____ R:_____ BP:_____ OX: _____Initials:_____

Provider's Notes: _____

_____

Provider's Signature Date

_____ _____