ExpressCare
Urgent Care Clinic
Walk-in Care + Occupational Medicine

Dutchtown • 13201 Hwy. 73, Ste. 102 • Geismar, LA 70734 • (225) 673-2088 • Fax (225) 673-2080
Goodwood • 8742 Goodwood Blvd. • Baton Rouge, LA 70806 • (225) 231-7070 • Fax (225) 231-7069
Highland • 4410 Highland Rd., Ste. A3 • Baton Rouge, LA 70808 • (225) 831-4025 • Fax (225) 831-4026
Perkins • 3235 Perkins Rd. • Baton Rouge, LA 70808 • (225) 387-3030 • Fax (225) 387-4521
Walker • 13466 Vera McGowan Rd. • Walker, LA 70785 • (225) 380-1720 • Fax (225) 380-1719

Original Date:	
Dates Revised:	

Name *(Last, First, M.I.):*	☐ M ☐ F	**SSN#:**
Address:		
City:	**State:**	**Zip:**
Telephone: ( )		
Company:		
Job Title:		

MEDICAL HISTORY

A. Have you *ever* had: (please answer all questions)

1. Cancer	☐	YES	☐	NO
2. Allergies	☐	YES	☐	NO
3. Hay fever	☐	YES	☐	NO
4. Hives	☐	YES	☐	NO
5. Poor vision	☐	YES	☐	NO
6. Glaucoma	☐	YES	☐	NO
7. False Teeth	☐	YES	☐	NO
8. Rhinitis	☐	YES	☐	NO
9. Broken bone	☐	YES	☐	NO
10. Diabetes	☐	YES	☐	NO
11. Thyroid trouble	☐	YES	☐	NO
12. Schizophrenia	☐	YES	☐	NO
13. Depression	☐	YES	☐	NO
14. Bipolar disorder	☐	YES	☐	NO
15. Anxiety attacks	☐	YES	☐	NO
16. Atopic dermatitis	☐	YES	☐	NO
17. Psoriasis	☐	YES	☐	NO
18. Fungal infection	☐	YES	☐	NO
19. Yeast infection	☐	YES	☐	NO
20. Tuberculosis	☐	YES	☐	NO
21. Chronic bronchitis	☐	YES	☐	NO
22. Asthma	☐	YES	☐	NO
23. Emphysema	☐	YES	☐	NO
24. High blood pressure	☐	YES	☐	NO
25. Heart murmur	☐	YES	☐	NO
26. Hepatitis	☐	YES	☐	NO
27. Peptic ulcer	☐	YES	☐	NO
28. Colitis	☐	YES	☐	NO

29. Hemorrhoids	☐	YES	☐	NO
30. Hernia	☐	YES	☐	NO
31. Arthritis	☐	YES	☐	NO
32. Pancreatic disease	☐	YES	☐	NO
33. Ruptured disc	☐	YES	☐	NO
34. Back trouble	☐	YES	☐	NO
35. Urinary bladder	☐	YES	☐	NO
36. Kidney trouble	☐	YES	☐	NO
37. Prostate trouble	☐	YES	☐	NO
38. Migraine headaches	☐	YES	☐	NO
39. Epilepsy	☐	YES	☐	NO
40. Stroke	☐	YES	☐	NO
41. Motion sickness	☐	YES	☐	NO
42. Sea sickness	☐	YES	☐	NO
43. Other illness	☐	YES	☐	NO
B. Do you *presently* have:				
1. Fever	☐	YES	☐	NO
2. Tire easily	☐	YES	☐	NO
3. Weight loss	☐	YES	☐	NO
4. Flushing	☐	YES	☐	NO
5. Frequent infections	☐	YES	☐	NO
6. Runny nose	☐	YES	☐	NO
7. Sore throat	☐	YES	☐	NO
8. Light headed	☐	YES	☐	NO
9. Swelling around eyes	☐	YES	☐	NO
10. .Eye trouble	☐	YES	☐	NO
11. Bags under eyes	☐	YES	☐	NO
12. Frequent headaches	☐	YES	☐	NO
13. Numbness	☐	YES	☐	NO
14. Tingling anywhere	☐	YES	☐	NO
15. Fits / seizures	☐	YES	☐	NO
16. Tremors	☐	YES	☐	NO
17. Dizziness	☐	YES	☐	NO
18. Get angry easily	☐	YES	☐	NO
19. Nervousness	☐	YES	☐	NO
20. .Depression	☐	YES	☐	NO
21. Rash	☐	YES	☐	NO
22. Itching	☐	YES	☐	NO
23. Skin sores	☐	YES	☐	NO
24. Productive cough	☐	YES	☐	NO
25. Dry cough	☐	YES	☐	NO
26. Chest pain	☐	YES	☐	NO
27. Wheezing	☐	YES	☐	NO
28. Shortness of breath	☐	YES	☐	NO
29. Wake up short of breath	☐	YES	☐	NO
30. Nausea and vomiting	☐	YES	☐	NO

31. Loose stools	☐	YES	☐	NO
32. Yellow eyes	☐	YES	☐	NO
33. Abdominal pain	☐	YES	☐	NO
34. Blood in stool	☐	YES	☐	NO
35. Dark urine	☐	YES	☐	NO
36. Burning on urination	☐	YES	☐	NO
37. Wake up at night to urinate	☐	YES	☐	NO
38. Leg pain from walking	☐	YES	☐	NO
39. Weak in arms or legs	☐	YES	☐	NO
40. Back pain	☐	YES	☐	NO
41. Joint stiffness	☐	YES	☐	NO
42. Trouble sleeping	☐	YES	☐	NO
FEMALES ONLY: Date of last menstrual period _____				

C. Are you allergic to any medication?	☐	YES	☐	NO
If "YES" please list:				
D. Do you take routine medication; prescription or over the counter?	☐	YES	☐	NO
If "YES" please list:				
E. Have you ever had any low back injuries or trouble with your low back?	☐	YES	☐	NO
If "YES" please list:				
F. Have you ever had any other major injury?	☐	YES	☐	NO
If "YES" please list:				
G. Have you ever had surgery to your back, knee, shoulder, elbow, hand or ankle? (please circle area)	☐	YES	☐	NO
H. Have you had any other surgery?	☐	YES	☐	NO
If "YES" please list:				
I. Please give the approximate year that you last received a tetanus injection:				

SOCIAL HISTORY

A. Do you use tobacco or tobacco products?	☐	YES	☐	NO
If "YES" please list:				

OCCUPATIONAL HISTORY

A. Are you capable of frequently lifting 100 pounds?	☐	YES	☐	NO
If "NO", how much can you lift?				
B. Have you ever had an injury or illness arising out of your employment	☐	YES	☐	NO
C. Have you ever had any sensitivity, become ill, or been removed from work from being around chemicals, fumes, sunlight, or dust?	☐	YES	☐	NO
D. Have you ever been exposed to asbestos?	☐	YES	☐	NO
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** _____

Comments on History:

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Physician/ P.A.