GRAND VIEW HEALTH

WORKPLACE HEALTH & WELLNESS

Workplace Health & Wellness
at Grand View Health
4 Lifemark Drive
Sellersville, PA 18960
215 453-4941

INITIAL VISIT MEDICAL HISTORY - INJURY

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

Employer: _____

Date of Injury/ Exposure: _____ How long at this job? _____

Time of Injury / Exposure: _____ Job Title? _____

Complaint: (What hurts?) Please indicate right or left side.

1. _____

2. _____

How did this happen? _____

_____

_____

_____

List any treatment received for this injury so far? _____

Have you injured this body part before? ☐ YES ☐ NO If yes, when? _____ Work related? ☐ YES ☐ NO

Personal Medical History:

Do you have any allergies: ☐ YES ☐ NO

LIST ALLERGIES HERE: 1. _____ 2. _____

3. _____ 4. _____

Current Medications: _____

Preferred Pharmacy & Address: _____

Surgeries: _____

Work Injuries: _____

Do you work for any other person or employer? ☐ YES ☐ NO

If yes, when was the last time you worked (hour & day) _____ What kind of work? _____

Do you have any hobbies? ☐ YES ☐ NO _____

Do you do physical activity outside of work (sports, remodeling)? ☐ YES ☐ NO _____

Do you smoke or chew tobacco? ☐ YES ☐ NO If yes, _____ pack per day.

Do you drink alcohol? ☐ YES ☐ NO If yes, _____ drinks per week?

Hand Dominance: ☐ RIGHT ☐ LEFT

By signing I state that the injury or exposure I sustained occurred as stated above and that all statements made are truthful and accurate.

Patient Signature: _____ Date: _____ Reviewer: _____