ALLIANCE OCCUPATIONAL MEDICINE

☐ 315 S. Abbott Ave., Milpitas CA 95035 tel. 408-790-2900
☐ 2737 Walsh Ave., Santa Clara CA 95051 408-228-8400

Patient History
English

(Si usted preferiria una version en Espanol por favor pidasela a la recepcionista.)

Last Name _____ , First Name _____ Social Security No. _____ Date _____

Please list ALL MEDICATIONS you are taking (including non-prescription medications):

(use bottom of page if needed - all medications unrelated to your injury or the safe performance of your job will remain strictly confidential)

☐ **None** 1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

Please list ALL ALLERGIES to MEDICATIONS (use bottom if needed)**:**

☐ **None Known** 1 _____ 2 _____ 3 _____

	Do you have a history of …	NO	YES
1	**Ulcer or severe indigestion?**	☐	☐
2	Bone / joint injury / arthritis / bursitis?	☐	☐
3	Pain in neck, upper back or shoulders?	☐	☐
4	Pain in elbows, wrists or hands?	☐	☐
5	Tendinitis / carpal tunnel syndrome?	☐	☐
6	"I perform repetitive hand tasks"	☐	☐
7	Pain in hips, knees, ankles or feet?	☐	☐
8	Do your feet or ankles swell?	☐	☐
9	Hernia or swelling near groin?	☐	☐
10	Diabetes or high sugar levels in blood/urine?	☐	☐
11	Kidney or bladder disease?	☐	☐
12	Liver disease or hepatitis?	☐	☐
13	High blood pressure?	☐	☐
14	Heart disease?	☐	☐
15	Chest pain / pressure?	☐	☐
16	Major surgeries or recent hospitalizations?	☐	☐
17	Any prior work related injuries or illnesses?	☐	☐
18	Any permanent restrictions or limitations?	☐	☐
19	Do you exercise regularly?	☐	☐
20	Any loss of vision?	☐	☐
21	Working in a hazardous environment with Chemicals, Asbestos, Lead, Noise etc…?	☐	☐
22	Do you smoke cigarettes? If yes, how much? _____ per day.	☐	☐
23	Do you drink alcohol? On average, how many per day? _____ beers or glasses wine / liquor	☐	☐
24	Any loss of hearing?	☐	☐
25	Any history of seizure, dizziness or passing out?	☐	☐
26	Any difficulty breathing, asthma or wheezing?	☐	☐
27	Ongoing skin disease or rash?	☐	☐
28	Any other medical / psychological conditions?	☐	☐
	Women only-		
29	**Are you pregnant?**	☐	☐
30	Any gynecologic disease ?	☐	☐
31	Date of last period / menstruation? _____		
	Neck / Upper Back / Shoulder / Arm / Hand Pain - Please answer:		
32	Are you mostly? ☐ Right Handed ☐ Left Handed		
33	"I use a computer about _____ hours per day." ☐ None		
34	"I mouse with: ☐ Right Hand ☐ Left Hand ☐ No mouse		

Please explain "YES" answers (use item number to identify problem):

_____

_____

_____

With my signature below, I am hereby authorizing Alliance Occupational Medicine to provide me with any medical treatment & tests deemed necessary for my injury or physical exam and further give permission to release relevant medical information about my ability to work to my employer. I further give my permission to release previous medical records pertaining to this injury. To the best of my knowledge my responses to the above are complete and accurate. I understand that an intentional omission or misrepresentation of my medical history could lead to disciplinary action at a later date.

_____

Patient / Applicant Signature

History reviewed by: ☐ Azar ☐ Zdimal ☐ Hashmi ☐ Braren ☐ Mehta ☐ Cooper _____