

Date: _____

PATIENT HISTORY

Thomas Youm, MD

WORKER'S COMPENSATION

RYC Orthopaedics, PC

Name _____	Employer _____
Address _____	Address _____
Phone(H) _____	DOB _____
(W) _____	Age _____
Insurance _____	SS# _____
WCB# _____	Requesting Doctor: _____
CC# _____	Address _____
	Phone _____
	Other Referral: _____

Initial Visit Date _____	Occupation _____
Age _____	Height _____
Eyes _____	Hair _____
Sex: M F	Weight _____
	Handed: R L
	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* _____