PACIFIC MEDICAL CLINIC

1534 E. Warner Avenue, Suite A
Santa Ana, CA 92705
(714) 557-5599 Fax (714) 557-5599

HEALTH QUESTIONAIRE & CONSENT FOR

RETURN TO WORK/REGULAR WORK EVALUATION

1. Today's Date:_____

2. Employee Name: _____
First M.I Last

3. Home Address: _____

_____

4. Phone Number: Home (_____)_____ Cell (_____)_____ Work (_____)_____

5. Social Security Number:_____ 6. Date of Birth:_____/_____/_____

7. Name of Employer/ Company:_____

8. Department:_____ 9. Supervisors Name:_____

10. First day of absence from work (if Applicable):_____

11. Date of first onset of illness or injury you are being treated for:_____

12. a) If injured, how did the injury occur? _____

_____

b) Where were you when the injury occurred? _____

c) List all body parts involved: _____

13. What are your chief complaints or symptoms for this illness or injury? _____

_____

HEALTH HISTORY

PAST SURGERIES: List any past surgeries with the approximate age at which they were performed.
If none, check here: _____NONE

PAST ACCIDENT: List any serious accidents or injures with approximate age at the time.
If none, check here: _____NONE

PAST ILLNESSES OR HOSPITALIZATIONS: List any serious past illness and/or hospitalizations and your approximate age. If none, check here: _____NONE

BACK/NECK INJURIES OR PROBLEMS: List any back or neck injuries and your approximate age or any ongoing or recurring aches or pain in your neck or back. If none, check here: _____NONE

CHECK THE APPROPRIATE BOX "YES" OR "NO" FOR ANY PAST OR CURRENT HISTORY OF THE FOLLOWING CONDITIONS AND/OR SYMPTOMS. PLEASE EXPLAIN ANY "YES" ANSWERS IN THE SPACE PROVIDED, TO INCLUDE ONSET DATE, DIAGNOSIS, MEDICATION AND PHYSICIANS NAME AND ANY CURRENT CONDITION OR LIMITATION

YES	NO		EXPLAINATION
		Allergies or sinus trouble (including drug allergies)	
		Skin disease	
		Head, neck or spinal injury	
		Seizure, convulsions or fainting	
		Dizziness or frequent headaches	
		Eye/vision problem (except corrective lens)	
		Hearing problems or disorders	
		Cardiovascular (heart or blood vessel) disease	
		Lung disease (include TB and asthma)	
		Nervous stomach, frequent indigestion or ulcer	
		Diabetes or thyroid disorders	
		Gallbladder or intestinal disease	
		Kidney disease (including stones or blood in urine)	
		Liver disease (including hepatitis or cirrhosis)	
		Urinary tract disorder	
		Chronic back or joint discomfort; arthritis	
		Permanent defect	
		Compensated for any work-related illness/injury	
		Psychiatric/mental disorder	
		Alcohol or drug abuse and/or treatment	
		Any other nervous disorder	
		Do you currently smoke? If yes, list amount	
		Currently taking any medications (If yes, list)	
		Currently suffering from any other disease?	

TO ALL EMPLOYEES:

This medical evaluation you will be receiving should in no way be interpreted by you as being complete physical examination or a substitute for follow-up care with your personal physician. This is a basic health evaluation to determine your physical ability to return to regular work and/or perform your normal job duties. Regardless of the results of this examination, we recommend that you still follow-up with your personal physician for your conditions, as prescribed by him or her.

Name of Personal/Family Physician, if any: _____

Date last seen by your Personal Physician:_____

MEDICAL RELEASE AND CONSENT

I, the undersigned, certify that all the information I have or will furnish in connection with this examination is and will be true and correct. Further, I understand that all tests, information learned and findings made by the physician in the course of this examination and any required follow-up tests/ examinations can and will be disclosed to my company management in accordance with applicable local, state and federal statutes. I hereby authorize the examining physician to disclose to my company all information learned and findings made in the course of this examination. I willingly agree and consent to this examination and to any required diagnostic tests to complete this examination."

If you fully understand and consent to the above release of medical information, please sign and date below:

_____ _____

DATE **SIGNATURE**