Name: Date:



Thomas Youm, MD 1056 Fifth Ave, NY, NY 10028

WORKER'S COMPENSATION

Age	DOB	Oc	cupation		E	mplo	yer	
Height	Weight	Eyes⊦	lair	Handed.	R L Sex: N	ИF	Race:	Wh BI Hisp Asian
Address_			nsurance)	Re	ferre	d by	
Chief Co	mplaint (maii	n problem)						
•			•					
What are	your present	complaints?						
Low did v	vour injury oo	our? (brief de		of agaid	ont)			
now dia y	our injury occ	ar (brier de	scription	oi accio	ent)			
Were you	injured by a	motor vehicle	? YES	NO				
Was the a	ccident repo	rted to your e	mployer	? YES N	10			
Where did	you receive	initial treatm	ent?					
Name o	f Doctor/Hosp	oital				Date	e	
Were yo	ou taken by:	AMBULANC	E C	CAR	WALK			
Xrays take	en: YES NO	AREA:						
Were you	treated by ar	nother doctor	? YES	NO	Name			
Were ther	e any operati	ons for this o	ondition	? YES	NO			
Date of	operation		Na	me of Ho	ospital			
Type of	operation							
Any cast f	or this condit	ion? YES	NO V	Vhat part	t of the body			
How big	was the cast	<u> </u>		How	long did you	ı wea	r the ca	st
What trea	tments have	you tried? N	othing					
Medicatio	ns(names, im	provement?)						
PT(#week	ks, improveme	ent?)						
Injections	(dates, locatio	on, types, imp	oroveme	nt?)				
Other(imp	rovement?)_						,	

Notes:	Studies? Xrays	MRI	_ CT Scan	<i>EMG</i>	6 Other	
At work you are required to: What limitations did you experience from the injury: Review of Systems: Have you had any of the following recently? Fever or Chills Blurred Vision Shortness of Breath Sore ThroatChest Pain Nausea/VomitingPainful Urination Rashes Easy Bleeding/Bruising Seizures Headaches Weight Loss If so, explain: Allergies Drug Allergies Tolerate NSAIDs? Y N Social Hx: Tobacco (former, current, how many a day for how many years) Alcohol (drinks/wk) Drugs Pregnant: Y N Marital Status: S M D W Sports/Activities 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 Sleep Apnea Cardiac Stent Blood Clot Coumadin/Aspirin/Plavix Explain: Prior Surgeries w/ dates Medications Preferred Pharmacy (Name, Address, Zip, Ph#) Signature of Patient Date Notes:	(When?Results?)					
What limitations did you experience from the injury: Review of Systems: Have you had any of the following recently? Fever or Chills Blurred vision Shortness of Breath Sore ThroatChest Pain Nausea/VomitingPainful Urination Rashes Easy Bleeding/Bruising Seizures Headaches Weight Loss If so, explain: Allergies Drug Allergies Tolerate NSAIDs? Y N Social Hx: Tobacco (former, current, how many a day for how many years) Alcohol (drinks/wk) Drugs Pregnant: Y N Marital Status: S M D W Sports/Activities 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 Sleep Apnea Cardiac Stent Blood Clot Coumadin/Aspirin/Plavix Explain: Prior Surgeries w/ dates Medications Preferred Pharmacy (Name, Address, Zip, Ph#) Signature of Patient Date Notes:	Are you presently working	ng? YES NO - If no	ot, when was th	e last da	ay you worked?	
Review of Systems: Have you had any of the following recently? Fever or ChillsBlurred VisionShortness of Breath Sore ThroatChest Pain Nausea/VomitingPainful Urination Rashes Easy Bleeding/Bruising Seizures Headaches Weight Loss If so, explain:	At work you are required	d to:				
Vision Shortness of Breath Sore ThroatChest Pain Nausea/VomitingPainful Urination Rashes Easy Bleeding/Bruising Seizures Headaches Weight Loss If so, explain:	What limitations did you	experience from the	ne injury:			
UrinationRashes Easy Bleeding/Bruising Seizures Headaches Weight Loss If so, explain:	Review of Systems: Ha	ave you had any of	the following re	ecently?	Fever or Chills Blurred	l
If so, explain:	Vision Shortness	s of Breath Sore	ThroatChest	Pain_	Nausea/VomitingPainf	ul
Allergies	Urination Rashes	Easy Bleeding/Bru	uising Seizu	res H	eadaches Weight Loss	
Social Hx: Tobacco (former, current, how many a day for how many years) Alcohol (drinks/wk) Pregnant: Y N Marital Status: S M D W Sports/Activities Family History: DIABETES HEART DISEASE CANCER HYPERTENSION STROKE If parent(s) deceased, underlying condition? Mother Father	If so, explain:					
Alcohol (drinks/wk) Drugs Pregnant: Y N Marital Status: S M D W Sports/Activities	Allergies	Drug A	llergies		Tolerate NSAIDs?	YN
Sports/Activities Family History: DIABETES HEART DISEASE CANCER HYPERTENSION STROKE If parent(s) deceased, underlying condition? Mother Father	Social Hx: Tobacco (fo	rmer, current, how	many a day fo	how ma	any years)	
Family History: DIABETES HEART DISEASE CANCER HYPERTENSION STROKE If parent(s) deceased, underlying condition? Mother Father	Alcohol (drinks/wk)	Drugs	Pregnant	: Y N	Marital Status: S M D	W
If parent(s) deceased, underlying condition? Mother Father	Sports/Activities					
Medical Hx: HEART LUNGS STOMACH LIVER KIDNEY BLADDER DIABETES HTN Sleep Apnea Cardiac Stent Blood Clot Coumadin/Aspirin/Plavix Explain: Prior Surgeries w/ dates Medications Preferred Pharmacy (Name, Address, Zip, Ph#) Signature of Patient Date Notes:	Family History: DIABE	TES HEART DIS	EASE CANCE	ER HYF	PERTENSION STROKE	
Sleep Apnea Cardiac Stent Blood Clot Coumadin/Aspirin/Plavix Explain: Prior Surgeries w/ dates	If parent(s) deceased,	underlying conditio	n? Mother		Father	
Prior Surgeries w/ dates	Medical Hx : HEART L	LUNGS STOMACH	H LIVER KIDN	IEY BLA	ADDER DIABETES HTN	
Prior Surgeries w/ dates	Sleep Apnea Ca	rdiac Stent	Blood Clot	_ Coun	nadin/Aspirin/Plavix	
Medications	Explain:					
Preferred Pharmacy (Name, Address, Zip, Ph#) Signature of Patient Notes:	Prior Surgeries w/ date	9S				
Preferred Pharmacy (Name, Address, Zip, Ph#) Signature of Patient Notes:						
Signature of Patient Date Notes:	Medications					
Signature of Patient Date Notes:						
Notes:	Preferred Pharmacy (N	lame, Address, Zi	p, Ph#)			
	Signature of Patient				Date	
Signature of Doctor	Notes:					
Signature of Doctor						
Signature of Doctor						
Signature of Doctor Date						
Signature of Doctor Date						
Signature of Doctor Date						
Signature of Doctor Date						
orginatare or bootor	Signature of Doctor				Date	