Name:
Date:

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

WORKER'S COMPENSATION

Age_____ DOB_____ Occupation_____ Employer_____

Height_____Weight____ Eyes___Hair____ *Handed:* R L *Sex:* M F *Race:* Wh Bl Hisp Asian

Address_____Insurance_____ Referred by _____

Chief Complaint *(main problem)*_____

_____

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(names, improvement?)_____

PT(#weeks, improvement?)_____

Injections(dates, location, types, improvement?)_____

Other(improvement?)_____

Studies? *Xrays* _____*MRI*_____ *CT Scan*____ *EMG*_____ *Other*_____

(When?Results?)_____

Are you presently working? YES NO - If not, when was the last day you worked?_____

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 Throat__Chest Pain__ Nausea/Vomiting __Painful 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:

*Signature of Doctor*_____ *Date*_____