



Yakima Worker Care
 409 S 12th Ave
 Yakima WA 98902
 Phone 509-575-2949
 Fax 509-575-5743

Sunnyside Worker Care
 1614 E Edison, Suite E
 Sunnyside WA 98944
 Phone 509-836-0075
 Fax 509-836-0077

Pasco Worker Care
 1500 W Court St
 Pasco WA 99301
 Phone 509-543-7717
 Fax 509-543-7721

Name _____
 Date of Birth _____

Medical History Form

General:

What activities and hobbies do you participate in on a regular basis? _____

Who is your primary care provider (PCP)? _____

Do you have regular wellness checks? Yes No How often? _____

Have you ever had other work-related injuries? Yes No

Please list any reasons for which you have had surgery and/or gone to the hospital (give dates)

Have you ever had injuries to the following areas?

Neck Yes No Back Yes No
 Knees Yes No Shoulders Yes No

Medications:

List all medications you are taking: _____

Herbal / naturopathic treatment and/or medications: _____

Any allergic reactions to medication? Yes No List: _____

Social history and habits:

Do you use tobacco? Yes No
 If yes, Smoke Chew Plan to stop Number of years smoked _____ Packs per day _____
 If no, Never used Quit in _____

Do you drink alcoholic beverages? Yes No
 Regularly (3+ times a week) Seldom /Occasionally

Do you use illegal or unprescribed medications? Yes No

Do you have a history of drug abuse or addiction? Yes No

Have you ever received treatment for drug/alcohol abuse? Yes No

Family History: Mark corresponding box for any family members with the following conditions.	Grand father	Grand mother	Father	Mother	Sibling	Child
Diabetes						
High Blood Pressure						
Heart Attack						
Stroke						
Epilepsy/Seizures						
Tuberculosis						
Cancer						
Alcoholism/Drug abuse/Addiction						
Depression						
Other Mental Health Issues						

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SYSTEMS: Have you had the following issues? No Yes For how long/
how long ago? Explain

GENERAL

Unexplained weight loss/gain				
Fever/fatigue				
Head injury/Traumatic brain injury				
List all cancers for which you have been diagnosed and/or treated (e.g., Lung, stomach/bowel, breast, cervical, prostate, etc.)				

EYES

Color blindness				
Continuous blurring of vision				
Double vision				
Glasses/contacts				
Other eye problems (specify)				

EARS

Hearing Loss				
Continuous ringing in ears				
Other ear problems (specify)				

NOSE/THROAT

Hay fever				
Sinus troubles				
Sleep disorder (e.g., sleep apnea)				
Other problems (explain)				
Nose				
Throat				
Neck				

LUNGS/CHEST

Continuous nagging cough/hoarseness				
Coughed up blood				
Wheezing				
Shortness of breath				
Asthma				
Pneumonia				
COPD				
Obstructive sleep apnea (Sleep disorder)				
Tuberculosis (TB)				
Scarring on chest x-ray				

HEART/BLOOD VESSELS

Ankle swelling				
Chest pain				
Atrial fibrillation				
Irregular heart beat				

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HEART/BLOOD VESSELS	No	Yes	For how long/ how long ago?	Explain
Heart attack				
Heart murmur				
High blood Pressure				
Stroke				
Elevated cholesterol				
Other heart or blood vessel problems (specify)				
HEMATOLOGY				
Hemophilia or bleeding disorder				
Clotting disorder				
Other blood dyscrasias (specify)				
GASTROINTESTINAL				
Difficulty swallowing or indigestion				
Unusual heartburn				
Vomited blood				
Change in bowel habits				
Cirrhosis				
Hepatitis (Yellow Jaundice)				
Gallbladder disease				
Ulcers				
Pancreatitis				
Colitis				
Diverticulosis				
Hemorrhoids				
Hernia				
Other GI problems (specify)				
URINARY				
Frequent Urination				
Getting up at night to urinate				
Kidney infections				
Kidney stones				
Bladder infections				
BONE/MUSCLE				
Joint aches				
Joint stiffness				
Fractures (Specify where)				
Chronic back pain				
Back disc disease				
Fibromyalgia				
Arthritis				
Other bone/muscle problems (specify)				

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NERVOUS SYSTEM	No	Yes	For how long/ how long ago?	Explain
Headaches				
Seizures/epilepsy				
Other nervous system problems (specify)				
ENDOCRINE/GLANDULAR DISORDERS				
Thyroid problems				
Diabetes (circle responses below)				
Type 1 Type 2	controlled by: diet/exercise alone		oral medication	insulin injections
Other endocrine problems (specify)				
Other immunosuppressive condition (specify)				
SKIN				
Lump or unusual thickening of skin				
Sore that does not heal				
Obvious change in wart or mole				
Other skin problem (specify)				
PSYCHOLOGICAL				
Anxiety disorder				
Depression				
Bipolar				
Schizophrenia				
Insomnia/sleep disturbance				
Other psychological issue (specify)				
MEN ONLY				
Prostate infection				
Prostate enlargement				
Testicle problem				
Other genital problems				
WOMEN ONLY				
Breast issues (lumps, etc.)				Date of last mammogram:
Uterus problems (e.g., Hysterectomy)				
Unusual bleeding or discharge				
Still having regular periods?				Date of last period:
Do you think you may be pregnant?				
Have you ever been pregnant?			#Pregnancies:	#Live births:

Patient Signature _____ Provider Signature _____ Date _____