"Your 'round the Clock Company Doc"

Dr. Gil's IMMEDIATE CARE & Occupational Health Center

3000 E. Division • Springfield, MO 65802

Initial Injury Questionnaire

Date of Injury:	Date of Visit:
Job Title:	
Pain Scale (Circle): 1 2 3 4 5 6 7 8 9 10	
Injured Body Part(s):	

Health History Review (If yes, please explain):

Did you or your employer initiate any treatment/first aid prior to your visit?

- ❑ Yes
- ❑ No

_____

_____

Where were you when the injury occurred? (ex. shop, warehouse, kitchen, garage)

_____

Have you seen any other healthcare professional regarding this injury?

- ❑ Yes
- ❑ No

_____

_____

Are you pregnant?

- ❑ Yes
- ❑ No

Do you smoke/chew tobacco or drink alcoholic beverages? If yes, how often?

- ❑ Yes
- ❑ No

_____

Do you currently use, or have you previously used any illegal substances?

- ❑ Yes
- ❑ No

_____

Do you have any known drug allergies? If yes, please list below.

_____

_____

Do you currently take any medications? If yes, please list them below.

_____

_____

_____

_____

Is your Tetanus Immunization up-to-date? If yes, when?

- ❑ Yes
- ❑ No

_____

Have you had any previous surgeries? If yes, please list.

- ❑ Yes
- ❑ No

_____

_____

_____

Do you have any on-going diagnoses? (ex. High Blood Pressure, Acid Reflux, etc.) If yes, please list below:

_____

_____

_____

Signature: _____ Date: _____