



Alabama Specialty Clinic and Urgent Care

PATIENT INFORMATION

Employment Physical

Today's Date _____/_____/_____

Patient's Name _____ Sex: M / F Marital Status: _____

Date of Birth: _____/_____/_____ Age: _____ Race: _____

Ethnicity: Not Hispanic, Hispanic, White, Other, Refuse Primary Language: _____

SS#: _____ - _____ - _____ Home Phone: _____

Cell Phone: _____, Work Phone: _____, Email: _____

Home Address: _____ City: _____ State: _____

Employer Physical Is For : _____ Occupation: _____

Phone Number: _____ Address: _____

City: _____ State: _____ Zip: _____

Last Employer: _____ Occupation: _____

Last Day Worked: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

Primary Physician Name: _____ City: _____ State: _____

Primary Pharmacy: _____ City: _____

Signature: _____

PATIENT HEALTH HISTORY FORM

PLEASE FILL OUT COMPLETELY

NAME: _____ DATE OF BIRTH: ____/____/____ TODAYS DATE: ____/____/____

List the names of all the medicines you take including any supplements or over the counter drugs:

_____	_____
_____	_____
_____	_____
_____	_____

Please list all allergies:

_____	_____
_____	_____

Your Medical History – Please check if you have or ever have any of the following diseases:

- | | | |
|--|---|---|
| <input type="checkbox"/> Acid Reflux (Gerd) | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heartbeats | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease/Emphysema |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraines | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Other: _____ | |

Your Surgical History – Please check if you have had any of the following Surgeries:

- | | | |
|---|--|---|
| <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back Surgery |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> C-section | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Cervical Disc | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Heart Valve |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Prostate | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Shoulder Surgery |
| <input type="checkbox"/> Knee Surgery | <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> None |
| <input type="checkbox"/> Other: _____ | | |

Your Family History – Please check if your Mother, Father, Brother or Sister ever had any of the following diseases:

- | | | |
|--|---|--|
| <input type="checkbox"/> Family History: High Blood Pressure | <input type="checkbox"/> Family History: Heart Disease | <input type="checkbox"/> Family History: Diabetes |
| <input type="checkbox"/> Family History: Prostate Cancer | <input type="checkbox"/> Family History: Kidney Disease | <input type="checkbox"/> Family History: Thyroid Disease |
| <input type="checkbox"/> Family History: High Cholesterol | | |

Your Social History:

- | | | | | |
|-----------------------------------|----------|--|---------------------------------|--------------|
| <input type="checkbox"/> Married | Alcohol? | <input type="checkbox"/> Current – Everyday | <input type="checkbox"/> Former | Amount _____ |
| <input type="checkbox"/> Divorced | | <input type="checkbox"/> Current – Some Days | <input type="checkbox"/> Never | |
| <input type="checkbox"/> Single | | | | |
| <input type="checkbox"/> Widowed | Tobacco? | <input type="checkbox"/> Current – Everyday | <input type="checkbox"/> Former | Amount _____ |
| | | <input type="checkbox"/> Current – Some Days | <input type="checkbox"/> Never | |

I Certify that the above information is accurate to the best of my knowledge. I understand withholding information be it intentional or by negligence to fill out this form, could result in improper medical care and could be a detriment to my health or even life threatening. I also understand that it can be caused for the termination of my employment.

Signature: _____

Authorization to Release Healthcare Information

Today's Date: _____/_____/_____

Print Name: _____ **Signature:** _____

Date of Birth: _____/_____/_____ **SS#** _____/_____/_____

I understand that I am here for one of the following: worker's comp injury, drug screen, breath alcohol test, physical, PFT, RFT, audiogram, TB skin test, shots, blood work, or other occupational need. I hereby authorize ASC Alabama Specialty Clinic to release to and speak with my employer regarding any and all medical information including the diagnosis and records of treatment, radiology reports, MRI's, lab work, and any tests results that have been obtained from other medical facilities, or rendered to me at ASC Alabama Specialty Clinic.

You may release information or speak with _____
(Company or person who sent you)

Regarding my care at your facility.

Signature of Patient: _____ **Today's Date:** _____/_____/_____

Witness Signature: _____