CAMARENA
OCCUPATIONAL HEALTH

Patient Intake Form

Formulario de Registro del Paciente

Check one option below / Marque una opción

☐ DOT(CDL) Certification
Certificación DOT (CDL)

☐ Physical Exam
Examen físico

☐ Drug Screen
Control antidopaje

☐ Injury Care
Cuidado de Lesiones

☐ Other: _____
Otro:

Patient Information

Informacion del Paciente

First Name_____ Last Name: _____ Middle Initial: ____
Primer nombre Inicial del segundo nombre

☐ Male Masculino ☐ Female Femenino ☐ Single Soltero ☐ Married Casado

Email: _____

Social Security # or Military DBN: _____ Drivers License # _____ Date of Birth: _____
De Seguro Social o DBN militar: Licencia de conducir # Fecha de cumpleaños:

Address: _____ Apt #: _____ City: _____ State: ____ Zip: _____
Dirección Ciudad Estado Código postal

Home phone: _____ Work phone: _____ Cell phone: _____
Teléfono de casa: Teléfono del trabajo: Teléfono móvil

Pharmacy: _____ Location: _____ Phone: _____
Farmacia Ubicación Teléfono

Employer Empleador

Company: _____ Location/Store #: _____
Nombre de Empresa Ubicación / Tienda #

Address: _____ Suite #: _____ City: _____ State: ____ Zip: _____
Dirección Ciudad Estado Código postal

Temp Employee ☐ Yes ☐ No Name of Agency: _____ Phone: _____
Empleado temporal Si No Nombre de la agencia Teléfono

Consent

Consentimiento

I confirm that the information I provided is true to the best of my knowledge. I will not hold Camarena Occupational Health, its providers, or staff responsible for any mistakes or missing information I may have included on this form.

Confirmo que la información que proporcioné es correcta según mi conocimiento. No haré responsable a Camarena Occupational Health, sus proveedores ni a su personal por errores u omisiones que yo haya cometido al completar este formulario.

Signature: _____ Print Name: _____ Date: _____
Firma Nombre en letra de molde Fecha

If you are here only for a DOT drug screen or breath alcohol test, you may skip this section. For all other services, please complete.

Si está aquí solo para una prueba de drogas o alcohol en el aliento del DOT, puede omitir esta sección. Para todos los demás servicios, por favor complétela.

I authorize Camarena Occupational Health to provide services deemed necessary by medical staff, including physical exams, diagnostic tests (e.g., labs, x-rays), treatments, injections, medications, and vaccines (after reviewing any required Vaccine Information Statements), as well as tests for communicable or other conditions.

Autorizo a Camarena Occupational Health a realizar los servicios que el personal médico considere necesarios, incluyendo exámenes físicos, pruebas de diagnóstico (por ejemplo, laboratorios, radiografías), tratamientos, inyecciones, medicamentos y vacunas (después de revisar las Declaraciones de Información sobre Vacunas), así como pruebas para detectar enfermedades transmisibles u otras condiciones.

Signature: _____ Print Name: _____ Date: _____
Firma Nombre en letra de molde Fecha

CAMARENA
OCCUPATIONAL HEALTH

Injury Information

Patient Details

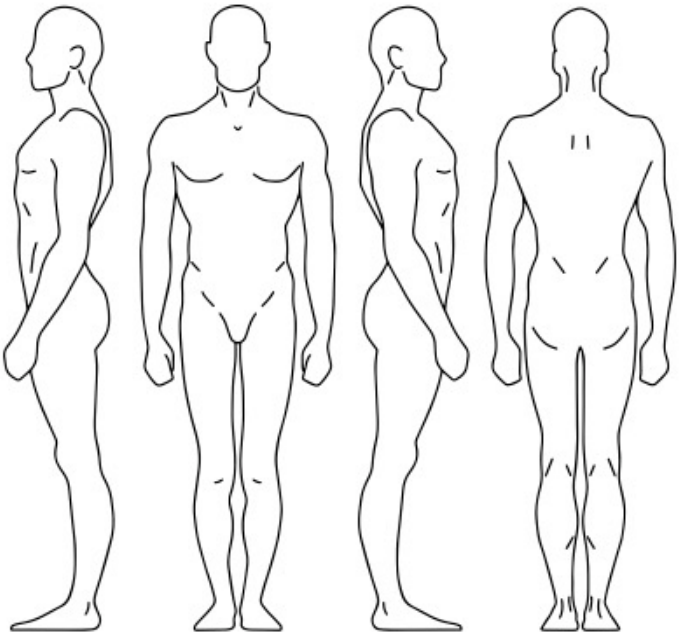
Last name: _____ First Name: _____ M.I.: __

Birthdate: _____ Phone(best contact): _____ Job Title: _____

Last Day Worked: _____ Chemical/toxins involved ☐ Yes ☐ No Material Safety Data available? ☐ Yes ☐ No

Injury Information

Injury Date: _____ Injury Time: _____ Injury Location: _____



Briefly explain what happened:

_____

_____

_____

Which area(s) of the body were affected?

_____

_____

_____

What side of the body is injured?
☐ Left ☐ Right ☐ Both

Have you been evaluated by another provider for this injury?

☐ No ☐ Yes If yes, Name: _____

Address: _____

City: _____ State:_____

Phone: _____

Signature: _____ **Print Name:** _____ **Date:** _____

CAMARENA
OCCUPATIONAL HEALTH

Patient Health History

Patient Information

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____ Age: _____ Sex ☐ Male ☐ Female Exam Date: _____

Visit Purpose:

_____

Allergies: ☐ No known drug allergies Reaction:

_____ _____
_____ _____
_____ _____
_____ _____

Medications **Dosage/Frequency** ☐ **No known current medications**

_____ _____/_____ _____ _____/_____
_____ _____/_____ _____ _____/_____
_____ _____/_____ _____ _____/_____
_____ _____/_____ _____ _____/_____
_____ _____/_____ _____ _____/_____

Other current medication details:

_____

Surgical History: ☐ No history Date Physician Hospital

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Additional surgery details:

_____

Medical History ☐ No history Date Comment

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Other Health Information:

_____

CAMARENA
OCCUPATIONAL HEALTH

Patient Health History

Work History

Job Type: _____ Job Duties: _____

Job Duration: _____ Prior Occupation: _____ Duration: _____

Social History

Alcohol Use: ☐ Yes ☐ No If yes, what kind: _____ Any Concerns? ☐ Yes ☐ No

Smoking: ☐ Yes ☐ No Frequency: _____ Caffeine intake: ☐ Yes ☐ No

Illegal Drugs: ☐ Yes ☐ No With a needle: ☐ Yes ☐ No

Other social details:

_____

Body System Overview

Constitutional Symptoms

Appearance: Normal Abnormal (Circle one)

Yes No (Check)

☐ ☐ Night sweats
☐ ☐ Fever
☐ ☐ Weight Loss or gain
☐ ☐ Fatigue

Comments: _____

Eyes/Vision

Yes No

☐ ☐ Blurred vision
☐ ☐ Double vision
☐ ☐ Glaucoma
☐ ☐ Discharge
☐ ☐ Itching
☐ ☐ Lacrimation (Watery Eyes)
☐ ☐ Pain
☐ ☐ Redness of eyes

Comments: _____

Ears/Nose/Throat/Mouth

Yes No

☐ ☐ Poor Hearing
☐ ☐ Dry mouth
☐ ☐ Sore throat

Comments: _____

Cardiovascular

Yes No

☐ ☐ Chest pain
☐ ☐ Chest tightness
☐ ☐ Tightness/pressure/squeezing
☐ ☐ Palpitations
☐ ☐ Prior heart attack
☐ ☐ Heart murmur
☐ ☐ Fainting

Comments: _____

Respiratory

Yes No

☐ ☐ Shortness of breath with exertion
☐ ☐ Shortness of breath with lying flat
☐ ☐ Asthma
☐ ☐ COPD
☐ ☐ Pneumonia

Comments: _____

Gastrointestinal

Yes No

☐ ☐ Blood in stool
☐ ☐ Ulcers
☐ ☐ Diarrhea
☐ ☐ Constipation

Comments: _____

CAMARENA
OCCUPATIONAL HEALTH

Patient Health History

Genitourinary

Yes No
- ☐ ☐ Kidney stones
- ☐ ☐ Frequent urination
- ☐ ☐ Bladder infection

Comments:_____

Skin

Yes No
- ☐ ☐ Cancer
- ☐ ☐ Bruising
- ☐ ☐ Rash
- ☐ ☐ Infection/ulcer
- ☐ ☐ Discoloration in legs

Comments: _____

Musculoskeletal

Yes No
- ☐ ☐ Arthritis
- ☐ ☐ Gout
- ☐ ☐ Sore muscles

Comments: _____

Hematologic/Lymphatic

Yes No
- ☐ ☐ Anemia
- ☐ ☐ Swelling
- ☐ ☐ Leukemia

Comments: _____

Endocrine

Yes No
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid disease
- ☐ ☐ Cushing's Disease

Comments: _____

Neurologic

Yes No
- ☐ ☐ Dizziness
- ☐ ☐ Stroke
- ☐ ☐ Headaches
- ☐ ☐ Difficulty walking

Comments: _____

Psychiatric

Yes No
- ☐ ☐ Anxiety
- ☐ ☐ Depression

Comments: _____

Allergic/Immunologic

Yes No
- ☐ ☐ Hay fever
- ☐ ☐ Sinusitis
- ☐ ☐ Immune deficiency

Comments: _____

Patient:

Signature: _____ Print Name: _____

Date:_____