U.S. HealthWorks
MEDICAL GROUP

WORK STATUS REPORT

Name. Last: Anderson First: Tiffany Date of Exam: 7/06/11 Case #: 118168567

SS#: XXX-XX-5133 Date of Birth: 8/22/70 Date of Injury: 6/29/11 Claim #: _____

Employer: SJC MOSQUITO & VECTOR Contact: JOHN STROH Tel.: (209) 982-4675 Fax: 209 982-0120

Claims Administrator: AIMS Tel.: (800) 444-6157 Fax: 916 563-1919

PATIENT STATUS Since the last exam, this patient's condition has:

☐ improved as expected ☐ improved, but slower than expected ☐ work status pending PR2
☐ worsened ☐ reached plateau and no further improvement is expected ☐ not improved significantly
☐ been determined to be non-work related

DIAGNOSES (Include ICD-9 code, if possible)

924.11 CONTUSION OF KNEE R

TREATMENT

☒ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for _____ weeks. ☐ Ergonomic Eval
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for _____ weeks. ☐ Other _____

☒ Meds / Supplies Dispensed TDAP

☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty _____ ☐ Work status to be determined by specialist

Estimated length of treatment is now _____ weeks

WORK STATUS ☒ First Aid Case

☒ Return / ☐ Continue... to work without restrictions.

☐ Off work until (Date) _____ Estimated period of total temporary disability _____ days.

☐ Off the balance of this shift only. Then RTW on (Date) _____ to ☐ Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.

☐ Return to work as of (Date) _____ with the restrictions indicated below. Estimated duration of modified duty is _____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ____ hrs/day
( ) No / ( ) Limited standing or walking to ____ hrs/day
( ) No / ( ) Limited overhead work to ____ hrs/day
( ) No / ( ) Limited stooping and bending to ____ hrs/day
( ) No / ( ) Limited kneeling or squatting to ____ hrs/day
( ) No / ( ) Limited ( ) Lift ( ) Pull ( ) Push
Up to: ( ) 10 lbs ( ) 25 lbs ( ) 50 lbs ( ) ___ lbs
( ) No climbing

( ) Sit down job.
( ) Must wear: ( ) Splint ( ) Immobilizer ( ) Back support ( ) Cage
( ) Other _____
( ) Must keep _____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
( ) Keyboard / ( ) _____
( ) Other _____
_____

☐ Medical status was discussed with employer representative. Name _____

If no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available.

DISCHARGE STATUS ☐ Return to full duty on (Date) _____ with no limitations or restrictions. Released from care without ratable disability or need for future medical care.

☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.

☐ NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

TREATING PROVIDER

Name ECK, JON L., M.D. Lic. # G67867 Date of Exam 7/06/11

Specialty _____ Signature _____ Signature on File

Issued at: USHW of California - Stockton, 3663 E. ARCH ROAD, SUITE # 400, STOCKTON, CA 95215 Tel: (209) 943-2202

Checkin Time 9:50 AM Checkout Time 11:18 AM Next Visit Date 7/13/11 Time 9:30 AM

U.S. HealthWorks MEDICAL GROUP

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

☐ Additional pages attached

Patient Last Anderson First Tiffany M.I. ____ Date of Exam: 7/6/2011 Case #: 118-168567

Occupation: ____ SS# ____ Date of Birth 8/22/70 Date of Injury 6/29/11 Claim # ____

Employer: SJ County Mosquito Cont Contact: ____ Tel: ____ Fax: ____

Claims Administrator ____ Tel: ____ Fax: ____

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "Other" applies, this report qualifies as mandatory.)

☐ Significant change in patient's condition ☐ Need for referral or consultation ☐ Info requested by: ____
☐ Significant change in work status ☐ Need for surgery or hospitalization ☐ Released from care ☐ Request for authorization
☐ Significant change in treatment plan ☐ Periodic Report (45 days after last report) ☐ Other: OFR

PATIENT STATUS Since the last exam, this patient's condition has:

☐ improved as expected ☐ improved, but slower than expected ☐ not improved significantly
☐ worsened ☐ reached plateau and no further improvement is expected ☐ been determined to be non-work related

SUBJECTIVE COMPLAINTS (Document and describe significant complaints.)

OBJECTIVE FINDINGS (Document significant exam findings, lab, imaging, and other diagnostic testing.)

Tdap given

DIAGNOSES (Include ICD-9 code, if possible)

abrasion/contusion (R) knee

TREATMENT

☑ Office Visit / Injury Treatment ☐ Start / ☐ Continue ☐ Therapy: ___ times / week for ___ weeks. ☐ Ergonomic Evaluation
☐ Start / ☐ Continue ☐ Chiro: ___ times / week for ___ weeks. ☐ Other ____
☑ Medications / Supplies Dispensed Tdap
☐ Consultation / ☐ Referral ☐ Requested / ☐ Pending. Specialty ____ ☐ Work status to be determined by specialist.
Estimated length of treatment is now ____ weeks

WORK STATUS ☒ First Aid Case

☒ Return / ☐ Continue to work without restrictions
☐ Off work until (DATE) ____ Estimated period of total temporary disability ___ days,
☐ Off the balance of this shift only. Then RTW on (DATE)____ to Full / ☐ Modified duty. ☐ Re-evaluate work status before next shift.
☐ Return to work as of ____ with the restrictions indicated below. Estimated duration of modified duty is ____ days.

( ) No work near moving machinery
( ) No / ( ) Limited use of R / L hand to ____ hrs/day
( ) No / ( ) Limited standing or walking to ____ hrs/day
( ) No / ( ) Limited overhead work to ____ hrs/day
( ) No / ( ) Limited stooping and bending to ____ hrs/day
( ) No / ( ) Limited kneeling or squatting to ____ hrs/day
( ) No / ( ) Limited ☐ Lift ☐ Pull ☐ Push
Up to: ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs ☐ ____lbs
( ) No Climbing

( ) Sit down job
( ) Must wear ☐ Splint ☐ Immobilizer ☐ Back support ☐ Cage
☐ Other ____
( ) Must keep____ elevated
( ) Keep wound/bandage clean and dry
( ) Must take a ____ minute stretch break every ____ minutes from
☐ Keyboard / ☐ Other: ____
( ) Other

☑ Medical status was discussed with employer representative ~~Edie Lucas~~ John Stroh

DISCHARGE STATUS

☐ Return to full duty on (DATE)____ with no limitations or restrictions.
☐ Patient discharged as permanent and stationary with either impairment, work restrictions and/or need for future medical care. A PR-4 to follow.
☐ NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

PRIMARY TREATING PHYSICIAN

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Name Jon Eck, M.D. Cal. Lic # ____ Date of Exam ____

Specialty: ____ Signature (Original) ____

Executed at: U.S. HealthWorks / Stockton, 3663 E. Arch Road, Suite 400, Stockton, CA 95215 Tel: (209) 943-2202 • Fax: (209) 943-2209

YOUR NEXT APPOINTMENT WITH THE DOCTOR IS:	YOUR NEXT APPOINTMENT WITH THE DOCTOR IS:
☐ MON ☐ TUE ☑ WED ☐ THUR ☐ FRI ☐ SAT	☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT
DATE: 7/13 TIME: 9:30AM ☐ Before / After Shift	DATE: ____ TIME: ____ ☐ Before / After Shift
PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.	PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

U.S. HealthWorks MEDICAL GROUP

BIL

(1)

WC Worksheet
New Patient

MA / NURSE NOTES. Dominant hand: ☐ Right ☐ Left Allergies: NKDA

Medications: Ibuprofen, Antianxiety Problems/Side effects: none.

☐ Yes ☒ No History of ulcers or gastritis? ☐ Yes ☒ No Possibly pregnant? Last Tetanus Toxoid: 2004

Occupational History: LMS - unknown.

Job Title: Pesticide Applicater Length of employment with company 6 yrs Average hours per week: 50

Main Job Characteristics At The Time Of Injury:

☐ Sit down job ☒ Prolonged standing or walking ☒ Repetitive use of hands / keyboard / mouse ☒ Kneeling or squatting

☒ Bending ☒ Stooping ☒ Climbing ☐ Overhead work ☒ Operating hand tools / Machinery

☒ Lifting / Pulling / Pushing ☐ Up to 10 lbs. ☐ Up to 25 lbs. ☒ Up to 50 lbs. ☐ Up to ____ lbs. Other: ____

☐ Yes ☒ No Any lost work time? If Yes, specify number of full days lost: ____ and last date worked: ____

☐ Yes ☒ No Any other source of employment? If Yes, specify: ____

☐ Yes ☒ No Any sports or hobbies? If Yes, specify: ____

☐ Yes ☒ No Any previous treatment for the complaint(s) before coming to U.S. HealthWorks? If Yes, specify: ____

Chief Complaint: Pain in (R) knee

Ht: 64 in Wt: 145 lbs Pulse: 64 /min BP 142/100 mmHg Resp: 16 /min Temp: 97.7 °F

140/100 120/100

Completed by: tt SMA

PHYSICIAN HISTORY (Explain any **Yes** answers below.)

☐ Yes ☒ No Chemical / toxic exposure involved?

☒ Yes ☐ No Any previous occupational injuries or illnesses?

☐ Yes ☒ No Any pre-existing condition that could complicate or prolong the patient's diagnosis, treatment, and/or rate of recovery?

Hx (R) knee arthroscopy for meniscus injy 2008 and 2009

Last Td 2004

History of Present Illness/Injury: (Describe below the mechanism of injury, progression of illness, and the characteristics of the chief complaint)

Walked into a T-bar 6/29/11 contused and scrapped medial (R) knee over a Trochar scar. C/O exposure to waste water from a dairy farm the next day. claims it feels funny

Chief Complaint #1: Pain (R) knee

Location: medial joint

Quality: ☐ Faint ☐ Sharp ☒ Dull ☐ Tingling ☐ Burning

Severity: ☒ Minimal ☐ Mild ☐ Moderate ☐ Severe

Duration: ____ Min ____ Hours 7 Days

Timing: ☒ Occasional ☐ Intermittent ☐ Constant

Context: at work

Modifying Factors: Exacerbated by: movement

Lessened by: Rest

Chief Complaint #2: ____

Location: ____

Quality: ☐ Faint ☐ Sharp ☐ Dull ☐ Tingling ☐ Burning

Severity: ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Duration: ____ Min ____ Hours ____ Days

Timing: ☐ Occasional ☐ Intermittent ☐ Constant

Context: ____

Modifying Factors: Exacerbated by: ____

Lessened by: ____

Relevant History. Comments:

(-) HTN, DM, PUD, kidney on Lupin B12

(+) Anxiety - Takes Xanax over seeing

NKDA

Denies pregnancy LMP 2-3 months ago. Refuses UPT

☒ As part of my evaluation, I reviewed the information above, as well as the patient's **Medical, Family and Social History** and the **Review of Systems** collected today.

Provider Signature

SJC MOSQUITO & VECTOR 159356

DOS: 7/06/11 DOI: 6/29/11 DOB: 8/22/70

Patient: Anderson, Tiffany

Case # : 118-168567 Ref # : Org 1174/s\

HE DOCUMENTATION ABOVE.

WC Worksheet
New Patient

ident #: ____ Date: ____

U.S. HealthWorks MEDICAL GROUP

HX1

PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE

WC

Please complete the following information. (Por favor, complete la siguiente información)

Employer (Patrón): S.J. County Mosquito Control Date (Fecha): 7-6-11 SSN: 549-23-5133

First Name (Nombre): Tiffany Middle Initial (Inicial): K Last Name (Apellido): Anderson

Address (Dirección): 2 N. Alvena Avenue City (Ciudad): Lodi State (Estado): CA Zip (C. Postal): 95240

Telephone Numbers (Teléfonos) Home: (Casa): 209-329-9523 Work (Trabajo): 209-982-4675 Cell (Celular): same

Best number to reach you (Mejor número para llamarle): ☐ Home: (Casa) ☐ Work (Trabajo) ☒ Cell (Celular) Email: tiffanyanderson@me.com

Date of Birth (Fecha de Nacimiento): 8-22-70 Sex (Sexo): F Marital Status (Estado Civil): Single

Date of Injury (Fecha de lesión): 6-29-11 Time (Hora): 2:15 Last day worked (Ultimo día que trabajo): NA

Occupation (Ocupación): pesticide applicator Address where injury occurred (Dirección donde ocurrió la lesión): 30138 E HWY 120 Escalon

Was your problem caused by something that happened at work? (¿Fue su problema causado por algo sucedido en su trabajo? ☒ Yes (Si) ☐ No

Injury was reported to (La lesion fue reportada a): Brian Heise Date (Fecha): 6-29-11 Time (Hora): 3:15

Has U.S. HealthWorks ever treated you before? (Alguna vez ha sido tratado en U.S. HealthWorks?): No When? (Cuándo?): NA

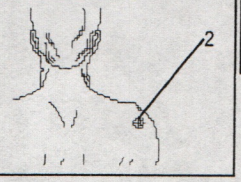
In case of emergency call: (En caso de emergencia llamar a:) Robert Blewett Tel: 415-516-5258

Please describe how your present injury/illness occurred. (Por favor describa cómo ocurrió su actual lesión o enfermedad.)

5153 I was walking around a dairy pond. I walked into a metal post holder by grass. The metal post broke open the skin to a post surgical incison. The following day the open wound was exposed to dirty water from pastures with animal waste.

PLEASE COMPLETE THE FOLLOWING DIAGRAM ***(Por favor complete el diagrama a continuación.)***

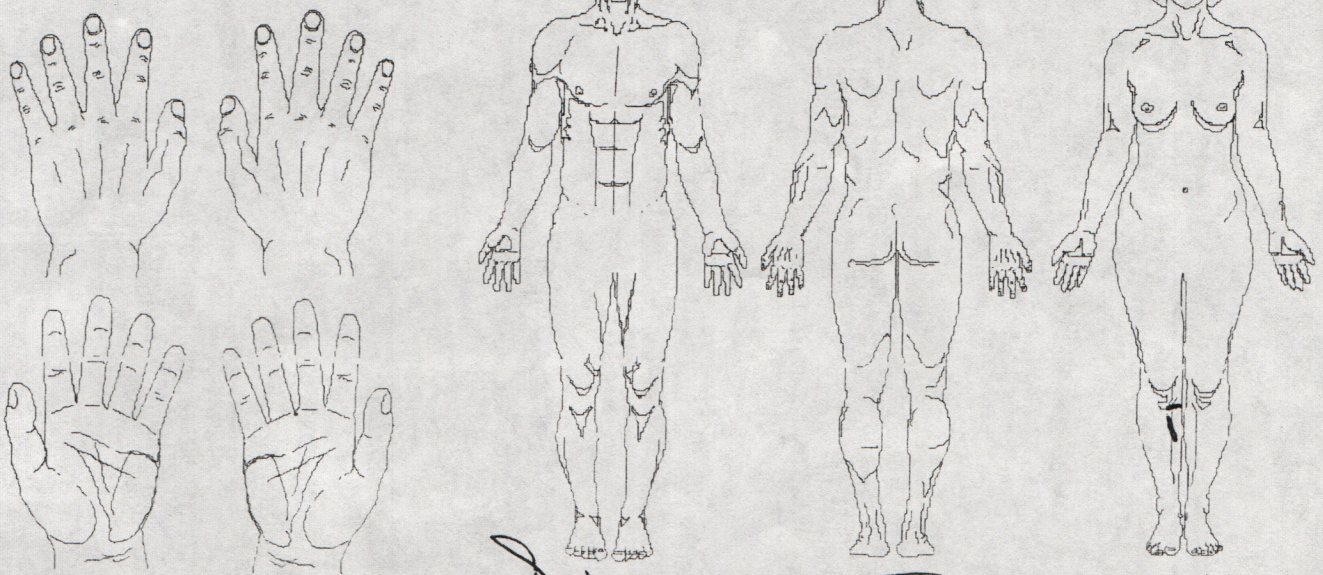
If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
(Si siente alguno de los síntomas listados a continuación, marque la zona del cuerpo en donde los siente en las figuras e indique el tipo de sintoma.

Symptoms (Síntomas)	Example (Ejemplo)
(1) Pain (Dolor)	
2. Numbness (Adormecimiento)	
(3) Burning (Quemazón)	
4. Pins/Needles (Pinchazos)	

Rate the intensity of your pain: / Indique la intensidad de su dolor:

NO PAIN / SIN DOLOR — MOST PAIN / DOLOR INTENSO

0 1 2 3 4 5 6 (7) 8 9 10



Patient Signature *(Firma del Paciente)* Date *(Fecha)* 7/6/11

ST1012 (11/09)

7/6/11

DIAGNOSES: (Specify all diagnoses by numbering in order of importance.)

#___ Open Wound _____ #___ Crush Injury _____ #___ ___ Degree Burn _____
___ Degree Burn _____ #1 Abrasion @ knee #___ _____
☑ **Work-related** ☐ **Not Work-related** ☐ **Pending determination.**
☑ **First Aid Case**

PHYSICIAN COMMENTS (Explain any No answers.)

1. ☑ Yes ☐ No According to the patient, was the present injury/illness caused by a single specific event?
2. ☐ Yes ☐ No Are findings consistent with the patient's statement?

TREATMENT PLAN:

☐ Cryotherapy locally for 15 min. STAT.
☐ Injection administered. Med/Manufacturer:_____ Dose:_____ Route:____ Location: _____ Lot: _____ Exp. Date: _____
☐ **Td** ☑ **Tdap** 0.5 mL IM STAT. Location: _____ Lot: ____ Exp. Date: _____
☐ For examination and treatment a **surgical tray with sterile instruments** was opened and prepared.
☐ A **sterile field** was prepared and sterile drapes were used.
☐ The wound was **cleansed and disinfected** with ☐ Saline ☐ Iodine Solution ☐ Hydrogen Peroxide Other: _____
☐ Local ☐ Regional ☐ Digital block **anesthesia** with [_____ mL] of ☐ Xylocaine ☐ Marcaine 1% / 1.5% / 2% ☐ w/ Epinephrine _____%
☐ The wound was **explored.**
☐ **Irrigation** and **drainage** performed. ☐ Simple ☐ Complex
☐ **Non-surgical debridement** performed: ☐ Infected ☐ Not-infected
☐ **Surgical debridement** performed with: ☐ Scissors ☐ Scalpel ☐ Dermatome ☐ Burr ☐ Other: _____
☐ **Sutures** / ☐ **Staples** were placed:
☐ Skin Sutures: #: ____ Type: _____ ☐ Tendon Sutures: #:_____ Type: _____
☐ Subcutaneous Sutures: #: ____ Type: _____ ☐ Fascia Sutures: #:_____ Type: _____
☐ **Antibiotic** ointment / ☐ **Silvadene** cream ☐ Nailbed Sutures: #:_____ Type: _____
☐ **Sterile dressing** was applied.
☐ **Patient tolerated procedure well** without complications.

Medications / Supplied (Check all that apply, write the prescription in the blanks and circle (D) for Dispensed and (P) for Prescribed.)

☐ Acetaminophen (Tylenol) ES 500 mg (#40) _____ D / P
☐ Acetaminophen/ Hyd. 500/5 mg (Vicodin) (#20) _____ D / P
☐ Cefadroxil (Duricef) 500 mg (#20) _____ D / P
☐ Naproxen Sodium (Aleve) 220 (#28) _____ D / P
☐ Ranitidine (Zantac) 150 mg (#20) _____ D / P
☐ Other _____ D / P
☐ Acetaminophen/ Cod. 300/30 mg (Tylenol #3) (#20) _____ D / P
☐ Cephalexin (Keflex) 500 mg (#40) _____ D / P
☐ Ibuprofen (Advil, Motrin) 200 / 600 / 800 mg (#40) _____ D / P
☐ Naproxen (Naprosyn) 375 (#40) / 500 mg (#20) (#40) _____ D / P
☑ Injectables. Specify: Tdap D / P
☐ Other _____ D / P

☐ **The following medical supplies were dispensed and the patient instructed in their proper use:**
1. _____ 2. _____ 3. _____

Other:

☐ **Interpreter used** ☐ **Certified interpreter unavailable.** Name: _____
Work Status: ☑ Regular work ☐ Modified work ☐ Off work. Explain: _____
☐ **Counseling visit:** Total duration of visit: _____ mins. Total duration of patient counseling: _____ mins. Refuses UDT
Return to clinic on: 7/13
☐ **Discharged from care.** No further treatment is anticipated at this center at this time.

MA/Nurse completing medical orders: _____

LABELS
Date 1ST L. J 7/06/11 Time 10:17
Medication Tdap Site R Delt
Dose 0.5ml Route IM
Manufacture Adacel
Lot # U3499 70AK Exp 11-2-13
VIS Publication Date 11/19/08

CONSULT / REFERRAL:

☐ **Patient advised to follow up with personal physician.**
☐ **Consult/** ☐ **Referral** ☐ ER ☐ Other: _____
Reasons:

PATIENT EDUCATION.

Patient voiced understanding of: ☑ **aftercare instructions** and **medication side effects**
☑ **work restrictions** and expected **progression of the injury**
Patient was given **educational material** on _____ ☐ **Krames Booklet** John Stroh

EMPLOYER CONTACT: ☑ **Discussed case** / ☐ **Left detailed message** with: Eddie Buckosi on the issues of:
☑ Causation ☑ Diagnoses ☑ Prognosis ☑ Work Status Other: _____

PROVIDER. Signature: _____ Name: Jon Eck, M.D.

SJC MOSQUITO & VECTOR 159356
DOS: 7/06/11 DOI: 6/29/11 DOB: 8/22/70
Patient: Anderson, Tiffany
Case # : 118-168567 Ref # : Org 1174/s

DOCUMENTATION ABOVE.

OPEN WOUNDS / BURNS
Page 2 of 2 *WC New Patient*

t #: _____ Date: _____

U.S. HealthWorks MEDICAL GROUP

HX2

WC HEALTH HISTORY / HISTORIA MEDICA

Confidential / Confidencial

To better assess your health condition, please provide the following information ((Para evaluar mejor su salud, por favor proporcione la siguiente información)

PLEASE ANSWER ALL QUESTIONS — **POR FAVOR, CONTESTE TODAS LAS PREGUNTAS**

Yes/Sí	No	PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS	
X		1. Allergies or hives	Alérgias o urticaria
X		2. Medications	Medicinas
	X	3. Major illnesses or injuries	Enfermedades/lesiones importantes
X		4. Hospitalizations or surgeries	Hospitalizaciones o cirugías
X	X	5. Motor vehicle accidents	Accidentes de tránsito
	X	6. Blood transfusions	Transfusiones de sangre
X		7 Worked in a hazardous environment	Trabajo en ambientes peligrosos
X		8. Work-related injuries/illnesses	Accidentes/enfermedades en el trabajo
	X	9. Permanent disabilities	Incapacidad permanente
Yes/Sí	**No**	**FAMILY HISTORY / ANTECEDENTES FAMILIARES**	
	X	10. Blood diseases in relatives	Familiares con enfermedades de la sangre
	X	11. Cancer or leukemia in relatives	Familiares con cáncer o leucemia
	X	12. Diabetes in relatives	Familiares con diabetes
	X	13. Heart Disease	Familiares con enfermedades del corazón
	X	14. High Blood Pressure	Familiares con presión alta
	X	15. Strokes in relatives	Familiares con trombosis / ataques cerebrales
	X	16. Mental illnesses in relatives	Familiares con enfermedades mentales
Yes/Sí	**No**	**SOCIAL HISTORY / ANTECEDENTES SOCIALES**	
	X	**17. Tobacco use. How much? NA week**	**Uso de tabaco.)Cuanto?_____ /semana**
	X	**18. Alcohol use. How much? NA week**	**Uso de alcohol.)Cuanto?_____ /semana**

REVIEW OF SYSTEMS / REVISION DE SISTEMAS

Have you had or do you commonly have:)Tiene usted normalmente o ha tenido:

Yes/Sí	No	CONSTITUTIONAL	
	X	19. Recent gain or loss of weight	Ganancia o pérdida de peso reciente
	X	20. Weakness, fatigue, or appetite loss	Debilidad, fatiga o pérdida de apetito
	X	21. Fever	Fiebre
Yes/Sí	**No**	**SKIN**	
	X	22. Skin diseases or problems	Enfermedades en la piel
X		23. Discoloration, pigmentation changes	Cambios de color en la piel
	X	24. Cancer/Tumors or cysts	Cáncer, tumores o quistes
		HEAD	
		25. Frequent or severe headaches	Dolores de cabeza frecuentes o severos
Yes/Sí	**No**	**EYES / VISION**	
	X	26. Eye injury, infection or pain	Lesiones, infección o dolor en los ojos
	X	27. Blurred, double or decreased vision	Visión borrosa, doble, o disminuída
	X	28. Eye itching, burning or tearing	Lagrimeo, picazón o quemazón en ojos
	X	29. Light sensitivity	Sensibilidad a la luz
Yes/Sí	**No**	**EARS, NOSE, THROAT, MOUTH**	
	X	30. Loss or decreased hearing	Pérdida o disminución de la audición
	X	31. Ear pain, infection, discharge	Dolor, infección o secreción en oídos
	X	32. Nose / Sinus Problems	Problemas en la nariz o en senos nasales
	X	33. Dental/Gum Disease	Enfermedades dentales o de las encías
	X	34. Recurrent throat problems	Problemas de garganta recurrentes
	X	35. Voice Change / Hoarseness	Ronquera o cambios en la voz
Yes/Sí	**No**	**CARDIOVASCULAR SYSTEM**	
	X	36. Shortness of Breath	Dificultad para respirar
	X	37. Chest Pain or Pressure	Opresión o dolor en el pecho
	X	38. Palpitation/Pounding Heart	Palpitaciones o saltos del corazón
	X	39. High Blood Pressure	Presión sanguínea elevada
	X	40. Swelling Feet/Ankles	Hinchazón de pies o tobillos
	X	41. Varicose Veins	Venas varicosas

Yes/Sí	No	RESPIRATORY SYSTEM	
	X	42. Chronic/Recurrent Cough/Cold	Resfriado / tos crónica o recurrente
	X	43. Asthma / Wheezing	Asma o pitos (sibilancias) en el pecho
	X	44. Emphysema or chronic bronchitis	Enfisema o bronquitis crónica
	X	45. Pneumonia	Pneumonía o pulmonía
	X	46. Tuberculosis	Tuberculosis
	X	47. Coughing of Blood	Tos con sangre
Yes/Sí	**No**	**GASTROINTESTINAL TRACT**	
	X	48. Frequent Indigestion or reflux	Indigestión o reflujo frecuentes
	X	49. Nausea or vomiting	Náusea o vómitos
	X	50. Vomiting of Blood	Vómitos con sangre
	X	51. Abdominal pain	Dolor abdominal
	X	52. Liver disease	Enfermedades del hígado
	X	53. Change in Bowel Habits	Cambios en hábitos intestinales
	X	54. Frequent Constipation/Diarrhea	Constipación o diarea frecuentes
	X	55. Blood in stools/Black stools	Heces negras o con sangre
	X	56. Hemorrhoids / Rectal Disease	Hemorroides o enfermedades del recto
Yes/Sí	**No**	**GENITOURINARY TRACT**	
	X	57. Painful or difficult urination	Dificultad o dolor al orinar
	X	58. Blood in urine	Sangre en la orina
	X	59. Kidney infection/stones	Infecciones o cálculos del riñón
	X	60. Venereal Disease	Enfermedades venéreas
Yes/Sí	**No**	**MUSCULOSKELETAL**	
	X	61. Joint pain or disease	Enfermedades o dolor en las articulaciones
	X	63. Neck or back injury	Lesiones del cuello o de la espalda
	X	64. Foot Problems	Problemas en los pies
Yes/Sí	**No**	**NEUROLOGICAL**	
	X	65. Epilepsy, Convulsions	Epilepsia, convulsiones, ataques
	X	66. Dizziness	Mareos o vértigo
	X	67. Muscle weakness or paralysis	Parálisis o debilidad muscular
	X	68. Numbness in arms or legs	Adormecimiento de manos o pies
Yes/Sí	**No**	**PSYCHIATRIC PROBLEMS**	
	X	69. Depression	Depresión
	X	70. Nervousness	Nerviosismo
	X	71. Mood swings	Cambios del humor o del carácter
	X	72. Sleep disturbances	Trastornos del sueño
	X	73. Alcoholism	Alcoholismo
	X	74. Drug abuse treatment/rehabilitation	Rehabilitación por adicción a drogas
Yes/Sí	**No**	**ENDOCRINE SYSTEM**	
	X	75. Increased appetite	Apetito exagerado
	X	76. Increased thirst	Sed exagerada
	X	77. Increased urination	Aumento en la frecuencia o cantidad de orina
	X	78. Diabetes/High Blood Sugar	Diabetes / Azúcar en la sangre
	X	79. Hair loss	Pérdida del cabello
Yes/Sí	**No**	**BLOOD DISORDERS**	
	X	80. Bleeding gums	Sangramiento por las encías
	X	81. Bruising	Moretones o cardenales
	X	82. Spontaneous nose bleeding	Sangramiento espontáneo por la naríz
	X	83. Easy bleeding or hard to stop	Sangramiento fácil o difícil de detener
Yes/Sí	**No**	**FOR WOMEN ONLY**	
	X	84. Pregnant?	Embarazada?
	X	85. Date last menstrual period?	Fecha última menstruación
	X	86. Irregular Menstruation?	¿Menstruación o períodos irregulares?
	X	87. Painful Menstruation	¿Menstruación o períodos dolorosos?

Please write the number of any Yes answers and explain each one of them in the space below.

Por favor, escriba el número de las preguntas en las cuáles haya contestado que SÍ y explique sus repuestas en este espacio.

1. I have allergies.
2. I take IB Profin and anxiety medication
4. Ive had 2 surgeries on my R. Knee
5. I was rerended 12-2010
7. I am exposed to Chemicals at animal waste water.
- Ive had two knee surgeries

I certify that the information above is correct. (Certifico que la información arriba es correcta)

Patient Signature (Firma del Paciente): [signature] **Date** (Fecha): 7/6/11

PROVIDER COMMENTS

☐ Relevant history was discussed and patient advised to follow up with personal physician

Provider Initials: [signature] 7/6/11

ST1012A 11/09