ExpressMED

BEDFORD OCCUPATIONAL ACUTE CARE (BOAC)

Manchester (Executive)
Manchester (K St.)
Salem

Name ______________________ Date ______________

SSN ______________________ PCP Name ______________________

Date of Last Examination ______________ PPC Address ______________________

PCP Phone ______________________ ______________________

What are we seeing you for today? ______________________

PERSONAL MEDICAL HISTORY:

Please circle yes (y) or no (n) if you have any of the following conditions or symptoms. Provide an explanation below.

RESPIRATORY

Asthma or Wheezing y / n
Bronchitis y / n
Frequent Colds y / n
Pneumonia y / n
Shortness of Breath y / n
Emphysema y / n

CARDIOVASCULAR

Trouble Breathing Lying down At Night y / n
High Blood Pressure y / n
Heart Murmur y / n
High Cholesterol y / n
Heart Surgery y / n
Irregular Heartbeat y / n
Chest Pain y / n
Fainting y / n
Blood Clots y / n
Heart Attack y / n
Heart Disease y / n
Diarrhea/Constipation y / n
Gall Bladder Problems y / n
Hepatitis or Liver Trouble y / n
Blood in Stools y / n

MUSCULOSKELETAL

Arthritis or Bursitis y / n
Tendonitis y / n
Carpal Tunnel or Neuritis y / n
Gout or Rheumatism y / n
Back Pain or Sciatica y / n
Hernia or Rupture y / n
Fractures or Bone Disease y / n
Degenerative Disc Disease y / n

ENDOCRINE

Diabetes y / n
Thyroid problems y / n

DIGESTIVE

IBS y / n
Colitis y / n
GERD y / n
Ulcers y / n
Vomiting/Diarrhea y / n
Abdominal Pain y / n

GENITOURINARY

Prostate Disease y / n
Kidney Stones y / n
Kidney or Bladder Problem y / n
Pain when Urinate y / n
Blood in Urine y / n
Reproductive Difficulty y / n
Sexual Dysfunction y / n
Menstrual Dysfunction y / n

NEUROLOGIC

Carpal Tunnel Syndrome y / n
MS y / n
Stroke y / n
Seizures y / n
Migraines/Bad Headaches y / n
Anxiety Disorder y / n
Depression y / n
Psychiatric Problems y / n
Dizziness or Fainting y / n

EENT

Glaucoma y / n
Cataracts y / n
Decreased Hearing y / n
Hearing Aids y / n

INFECTIOUS DISEASES

Tuberculosis y / n
HIV or Low Immunity y / n
Venereal Diseases y / n
Frequent Infections y / n

DERMATOLOGY

Chronic Rashes, Itching y / n
Allergies y / n
Psoriasis y / n

HEMATOLOGY/ONCOLOGY

Anemia or High Iron y / n
Easy/Excessive Bleeding y / n
Cancer Leukemia y / n
Blood Transfusions y / n
Cancer y / n
- Type ______________

Explanation or Other Medical Problems:

____
____
____

Current Medications taken routinely
(Including any over-the-counter drugs, herbal products or vitamin supplements):

____
____

IMMUNIZATIONS

All Childhood Shots Finished y / n
Year of most recent Tetanus ______________
Year of Hepatitis A Series ______________
Year of Hepatitis B Series ______________
History of Varicella (chicken pox) y / n

List any allergies to* MEDICINES *as well as any other allergies
(Peanut Butter, Bee's, Latex, etc.):

____

URGENT CARE ONLY

Member	Age	Good Health	Poor Health	Deceased	List Cause of Death	Heart Disease	High Blood Pressure	Stroke	Diabetes	Cancer	Glaucoma	Psychiatric Disorders	Lung Disease	List Other
Mother														
Father														
Brother														
Sister														

HOSPITILAZATION(S):

Reason	*Date*	*Hospital*

PSYCHIATRIC HOSPITILAZATION(S) *[including inpatient/outpatient treatment for addiction/behavioral or mental health problems*]

Reason	*Date*	*Hospital/Mental Health Facility/Therapist*

SURGICAL HISTORY:

Reason	*Date*	*Hospital*

HABITS

Smoking

☐ Non-Smoker ☐ Smoker # Packs/Day ____________

☐ Ex-Smoker Month/Year Quit ____________ Plans To Quit: ☐ Yes ☐ No

Alcohol

☐Rarely ☐ 1-3/week ☐ 6-12/week ☐ Treated for Substance Abuse → y / n In Recovery → y / n

☐ Never ☐ 4-6/week ☐15+/week ☐ Ever Charged with DUI → y / n

Exercise

How Often: ______________________________ What Type: ______________________________

Job Position ______________________________ Date of Hire (W/C Only) ____________

Job Duties (W/C Only) ______________________________

OCCUPATIONAL HISTORY (for NON-URGENT CARE ONLY)

Job Title / Type	*Years*	*Exposures (i.e., dust, solvents, radiation, heat, cold, noise)*

Do you feel that you have/had any health problems related to your work? *Please describe:* ______________________________

List any previous Worker's Compensation injuries	***Date***	***Employer***

Describe any hobbies that expose you to chemicals, noise, fumes, or hazardous substances: ______________________________

Circle the protective equipment that you are familiar with using:

Hearing Protection Dust Mask Gloves Safety Glasses Respirator Hardhat Back/Gait Belt

By my signature I attest that this information is complete and truthful.

______________________________ Signature ____________ Date

PROVIDER COMMENTS: ______________________________