OMAC Claimant Information Sheet

Name: ______________________ Gender: __________ Date: ________

Address: ______________________________ Phone #: (____) __________

Employer at time of injury: ______________________ Claim #: ____________

Birth date: ______ Injury date: _________ SS#: ____________ Marital Status: ______

Dependents: __________ Education: ____________ Military service: __________

Tobacco (pks/day): _____ Alcohol (drinks/wk): ________ Illicit Drugs (list): ____________

Hobbies (list): ____________________ Exercise (type, times/wk): ___________

Medications: ____

Previous surgeries: ____

Occupational history (please list other occupational diseases or injuries): ____________

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Allergies: ____

Family history (age, deceased, cause of death, illnesses):

Mother: ____________________ Father: ______________________

Chronic medical conditions: ____________________________________

Current work status:

Working now? _____ If not, why not: ______________ Benefits: ____________

List condition(s) accepted by your claim: ______________________________

Claimant Signature: ____________________________ **Date:** __________

For Office Use Only

Ht: _______ Wt: ______ BP: _____ Pulse: ________ Temp: ______ Dom. hand: _____

IME Physicians: ____

Exam Type: ____________ Priority: ______ IME Location: ________________

Claims Manager: ______________________ Claims Company: ____________

MEDICAL HISTORY

HEENT: Please check all that apply to you:

Do you wear glasses or contacts____
Have you ever had any foreign body in your eyes____
Have you ever experienced weak eyes____
Eye Surgery____
Recurrent ear infections____
Any problems with sinuses or nasal passages____
Do you experience double vision____
Tear duct problems____
Hearing problems____

CARDIO RESPIRATORY: Please circle all that apply to you:

Asthma	Unusual shortness of breath	Chest pain	Hear murmur
Night sweats	Irregular heart beat	Coronary artery disease	High blood pressure
Chronic cough	Elevated cholesterol		

GASTROINTESTINAL: Please circle all that apply to you:

Problems with swallowing	Appetite problems	Digestion	Nausea
Vomiting	Vomiting blood	Ulcers heartburn	Acid reflux disease
Jaundice	Hepatitis	Bowel or bladder problems	Rectal bleeding
Gall bladder disease/Fatty food intolerance			

GENITOURINARY: Please check all that apply to you:

Kidney disease____
Sexually transmitted disease____
Trouble urinating____
Bladder infection____
Prostate problems____
Pelvic inflammatory____

Please circle any of the following that apply to you:

HEMETOLOGIC
Anemia/Leukemia
Lymphoma
Varicose Veins
Abnormal cell count
Abnormal platelet count
Am on blood thinners

DERMATOLOGIC
Rashes
Eczema
Psoriasis
Fungal infection
Unusual moles
Skin cancer
Severe acne
Skin Biopsies
Tattoos

ENDOCRINOLOGIC
Thyroid problem
Pituitary gland
Adrenal gland
Pancreas/Diabetes

NEUROPSYCHIATRIC: Please circle all that apply:

Convulsions	Mental Illness	Mood swings	Anxiety	Depression
Anger control	Sleep problems			

MUSCULOSKELETAL: List any fractures or broken bones including dates:

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Systemic arthritis_____ Neck or back pain____