Mount Sinai

Selikoff Centers for Occupational Health

Welcome Packet

Mount Sinai *Selikoff Centers for Occupational Health*

Welcome to the Mount Sinai Selikoff Centers for Occupational Health

Dear Patient:

Welcome to the Mount Sinai Selikoff Centers for Occupational Health.

To ensure the highest quality care, we need certain information from you. Please fill out this packet to the best of your ability and bring it with you to your first appointment, along with any relevant medical records.

The following sections are included in this packet:

- **Registration/Demographic Information**
- **Other Treating Physician Information**
- **Workers' Compensation Information**
- **Employment Information**
- **Medical History Questionnaire**

In advance of your first appointment, a benefits counselor on our staff will contact you to discuss our services and answer any questions you may have. You also can contact us with any questions or for directions to our clinical centers at 1.888.702.0630. Visit us on the web at www.mountsinai.org/selikoff.

We look forward to seeing you!

Sincerely,

The Mount Sinai Selikoff
Centers for Occupational Health

Demographic Information

PATIENT INFORMATION		
Today's Date:	**Visit Date:**	
Last name:	**First**:	**Middle**:
Street address/PO Box:	**City**:	**State:**
County:	**Zip:**	**Country of Birth:**
Email address:		
Cell/Mobile phone: ( )	**Home phone**: ( )	**Work Phone**: ( ) **Ext**:
Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	**Date of Birth:** / /	**Sex**: ❑ M ❑ F
Race/ Ethnicity: ❑ Asian ❑ Black ❑ Hispanic ❑ Native American ❑ White		

IN CASE OF EMERGENCY		
Please notify in case of emergency:	**Relationship to patient**:	
❑ Check if address is the ***same*** as in patient information		
Address:	**City, State**:	**Zip**:
Home phone: ( )	**Work/cell phone**: ( )	

REFFERAL SOURCE

Please tell us how you found out about the Selikoff Centers for Occupational Health

Referring Source (Please check all that apply):

❑ Brochure ❑ Employer ❑ Internet ❑ Physician/Clinic ❑ NYCOSH ❑ Family/friend/Co-worker ❑ Lawyer ❑Self

❑ Community Group ❑ Government Agency ❑ Media ❑ Clergy ❑ 800-MD-SINAI ❑ Mount Sinai Website ❑ Insurance

❑ Other: _____

❑Union/ Name of Union and Local number: _____

❑ *Check if this is a* ***second opinion***

Referral Name:	
Referral E-mail:	
Referral Address:	
Referral Phone: ( )	**Referral Fax**: ( )

Physician Information

Patient Last Name:	Patient First Name:	Patient DOB:

OTHER TREATING PHYSICIANS

Please complete the below information to the best of your ability to let us know what physicians you are already seeing outside of the Selikoff Centers for Occupational Health.

1. Primary Care Physician:		
Address:		Phone: ( )
Fax: ( )	Conditions Treated:	
2. Other Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	
3. Other Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	
4. Other Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	
5. Other Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	
6. Other Physician name:	Specialty/Conditions Treated:	Address:
Phone: ( )	Fax: ( )	

PHARMACY INFORMATION

Pharmacy Name:		
Pharmacy Address:	**City, State:**	**Zip:**
Pharmacy Phone: ( )	**Pharmacy Fax: ( )**	

The above information is true to the best of my knowledge.	
Patient/Guardian signature:	**Date:**

Workers' Compensation Information

Patient Last Name:	Patient First Name:	Patient DOB:

WORKERS' COMPENSATION

Please provide the information below to the best of your ability. If this is a new case, you may not have all of this information available to you today. Please complete as much information as possible. Employers are required to post information about Workers' Compensation coverage in their place of business. Workers' Compensation Carrier Information can also be obtained through your employer's human resources department.

Patient Information (A.)

Workers' Compensation Carrier Case #:	Workers' Compensation Case# (If known):	Date of Injury/Onset of Illness: / /
On the date of injury/illness what was your job title and description:		
On the date of injury/illness what were your work activities:		

Employer Information (B.)

Employer When Injury Occurred:			
			Employer Phone #
Employer Address:			
City:	State:	Zip:	Phone:

Workers' Compensation Carrier Information:

Employer Insurance Carrier:	Carrier Code:
Insurance Carrier's Address:	

Occupational History

Patient Last Name:	Patient First Name:	Patient DOB:

OCCUPATION INFORMATION:

Current Employer Name:

Address of Employer:

City:	**State:**	**Zip:**	**Phone:**

Are you currently working? ☐ Yes ☐ No ***If no*, please indicate one of the following:**

☐ Disability ☐ Retired ☐ Unemployed/ laid off

Is/ was job located in New York State? ☐ Yes ☐ No

Are you a member of a labor union? ☐ Yes ☐ No

If yes, what is the name of your union and the local you are in?

Please write out your PRESENT (*or MOST RECENT, if not currently working*) job title or position.
Be as specific as possible:

_____

Current (*or most recent*) Industry: ***(check one)***

☐ Arts & Recreation	☐ Manufacturing (*specify product*: _____)
☐ Communications- telephone, radio, etc. (*specify type*:_____)	☐ Media- newspaper, magazine, TV, etc. (*specify*: _____)
☐ Construction: ☐ Bridges, tunnels, streets, utility, etc. ☐ buildings -residential, warehouse, industrial ☐ Trade contractors -plumbing, electrical, carpentry, etc. ☐ other (*specify*:_____)	☐ Membership Organizations- labor unions, religious/ political, etc.
☐ Educational Services & Schools: ☐ elementary, secondary, high schools ☐ colleges, universities, professional schools ☐ libraries	☐ Personal Services & Private Household Services
☐ Engineering	☐ Police & Law Enforcement
☐ Environmental Services	☐ Retail Sales (*specify product/service* _____)
☐ Financial Industry	☐ Safety & Protection Services- fire, security, etc.
☐ Government (specify agency type: _____)	☐ Social Services- counseling, family, child, etc.
☐ Health & Medical -hospital, clinics, labs, etc.	☐ Transportation (*Specify - air, bus, rail, water, etc.*_____)
☐ Healthcare- other (*specify*: _____)	☐ Wholesale Trade
☐ Legal Services- attorneys, courts, etc	☐ Other

Occupational History (continued)

Patient Last Name:	Patient First Name:	Patient DOB:

Please write out your PAST job title or position, if related to your current health condition.
Be as specific as possible:

_____

Current (*or most recent*) Industry: ***(check one)***

☐ Arts & Recreation	☐ Manufacturing (*specify product*: _____)
☐ Communications- telephone, radio, etc. (*specify type*:_____)	☐ Media- newspaper, magazine, TV, etc. (*specify*: _____)
☐ Construction: ☐ Bridges, tunnels, streets, utility, etc. ☐ buildings -residential, warehouse, industrial ☐ Trade contractors -plumbing, electrical, carpentry, etc. ☐ other (*specify*:_____)	☐ Membership Organizations- labor unions, religious/ political, etc.
☐ Educational Services & Schools: ☐ elementary, secondary, high schools ☐ colleges, universities, professional schools ☐ libraries	☐ Personal Services & Private Household Services
☐ Engineering	☐ Police & Law Enforcement
☐ Environmental Services	☐ Retail Sales (*specify product/service* _____)
☐ Financial Industry	☐ Safety & Protection Services- fire, security, etc.
☐ Government (specify agency type: _____)	☐ Social Services- counseling, family, child, etc.
☐ Health & Medical -hospital, clinics, labs, etc.	☐ Transportation (*Specify- air, bus, rail, water, etc.*_____)
☐ Healthcare- other (*specify*: _____)	☐ Wholesale Trade
☐ Legal Services- attorneys, courts, etc	☐ Other (*specify*: _____)

Occupational History (continued)

Patient Last Name:	Patient First Name:	Patient DOB:

Please complete the table below listing your past employment history:
On the following table, please list all jobs, beginning with your current or most recent position since you began working. Include short term, seasonal, and part time employment.

This is important information for your evaluation.

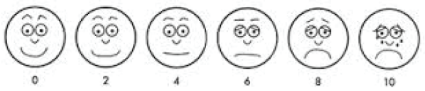
Name of Employer	Start Date	Last Day Worked	Full time or part time	List any known exposures	List any protective equipment that you used at this job.	Were you off of work for a health problem or injury at this job?

Medical History Questionnaire

Patient Last Name:	Patient First Name:	Patient DOB:

PATIENT MEDICAL HISTORY QUESTIONNAIRE

What is the reason for this visit?

Pain Scale On a scale from 1-10 please measure your pain. 0 – No Pain/Lowest level of Pain 10 – Highest Level of Pain	 No/low pain High pain	**(Please check (✓) the appropriate level)**
Immunizations: *Pneumovax* (pneumonia Vaccine) Influenza ("Seasonal Flu Shot")	❑ Yes ❑ No ❑ Yes ❑ No	Date of Immunization: Date of Immunization:

Past Medical History:		
General (weight change, fatigue, fever, loss of appetite)	❑ Yes ❑ No	(Please specify)
Heart disease (heart attack, congestive heart failure, angina, irregular heartbeat/arrhythmia)	❑ Yes ❑ No	(Please specify)
High blood pressure or low blood pressure	❑ Yes ❑ No	(Please specify)
Sore throat, Sinus problems	❑ Yes ❑ No	(Please specify)
Lung disease, including asthma, emphysema or shortness of breath	❑ Yes ❑ No	(Please specify)
Gastrointestinal problems (including ulcer, diverticulitis, spastic colon, bleeding from rectum)	❑ Yes ❑ No	(Please specify)
Liver disease	❑ Yes ❑ No	(Please specify)
Kidney or bladder disease	❑ Yes ❑ No	(Please specify)
Skin disorder (including hives, rash, swelling)	❑ Yes ❑ No	(Please specify)
Neurologic disorder (e.g., seizure, frequent headache, dizziness, fainting)	❑ Yes ❑ No	(Please specify)
Psychological/psychiatric disorder	❑ Yes ❑ No	(Please specify)
Blood disorder (including problems with bleeding, clotting or easy bruising)	❑ Yes ❑ No	(Please specify)
Diabetes or low blood sugar	❑ Yes ❑ No	(Please specify)
Thyroid disease	❑ Yes ❑ No	(Please specify)
Arthritis, muscle, bone disorder (including fracture)	❑ Yes ❑ No	(Please specify)
Immune system disorder (including lupus, HIV, AIDS)	❑ Yes ❑ No	(Please specify)
History of cancer	❑ Yes ❑ No	(Please specify)
Other	❑ Yes ❑ No	(Please specify)

Patient Last Name:	Patient First Name:	Patient DOB:

PATIENT MEDICAL HISTORY QUESTIONNAIRE (continued)

Surgical History Have you had any type of surgery (e.g., heart, abdominal, orthopedic, oral, eye, transplant)?	❑ Yes ❑ No	(Please specify)
Allergy History Have you ever had a ***severe*** allergic reaction (e.g. bee stings, food {milk, nuts}?	❑ Yes ❑ No	To what? _____ What type of reaction? _____
Have you ever had an allergic action to ***any*** medications (antibiotics, Codeine, etc)?	❑ Yes ❑ No	To which medication? _____ What type of reaction? _____

Medication History Please list all medications you are ***now*** taking. How much/how often?	Name of Medication:	/ Dose:	Frequency:
	_____	/ _____	_____
	_____	/ _____	_____
	_____	/ _____	_____
	_____	/ _____	_____
	_____	/ _____	_____

Family History		
Are there any conditions or diseases **related to your complaint** that run in your family?	❑ Yes ❑ No	Relative:_____ _____ _____ Condition/Disease:_____ _____ _____

Social History		
Do you have a history of smoking? If **YES,** how much did/do you smoke?	❑ Yes ❑ No	Did you quit? If so, when? Date:_____ Currently smoking? How many packs a day? _____
Do you drink alcohol? If **YES,** how much did/do you drink?	❑ Yes ❑ No	How many glasses per day? _____
Do you have a history of drug abuse? If **YES,** how much did/do you use?	❑ Yes ❑ No	Please explain:

What is the highest level of schooling you have completed?

☐ Grade 8 or less, specify grade completed _____	☐ Four year college, did not graduate, # years completed _____
☐ Some high school, specify grade completed _____	☐ Graduated from four year college
☐ Completed high school	☐ Attended professional/graduate school, # years completed ____
☐ Two year junior college	☐ Completed professional/graduate school

Patient Name:	**Patient Signature**:	**Date**:
Physician Name:	**Physician Signature:**	**Date:**