TOTAL URGENT CARE

Workplace Health Registration Form

Please fill out form completely and legibly.

Patient's Full Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Street Address:

City, State, Zip: _____

Email Address: _____

Phone: _____ Cell Phone: _____

Carrier: Comcast Other: _____

Preferred Contact Method: Phone Text Email Mail

Would you like to be reminded of your appointment? Yes No

How many days before?: _____ day(s)

Primary Care Physician: _____

Physician Phone: _____

How did you hear about us?: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race: ☐ American Indian or Alaskan Native ☐ Asian
☐ Black or African American ☐ White
☐ Native Hawaiian or Pacific Islander

Social Security No: _____

Marital Status: ☐ Child ☐ Single ☐ Married
☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact: _____

Emergency Phone: _____

Relationship to Patient: _____

Injured at?: Work Home Other: _____

Employer: _____

Employer Address: _____

_____

Employer Phone No: _____

Employer Contact: _____

Motor Vehicle Accident?: ◯ Yes ◯ No

Date of Injury/Illness: _____ Time: _____(a/p)

Date last worked: _____ (m/d/yy)

Occupation: _____

Reason for Visit: ◯ Physical ◯ Drug/Alcohol

Immunization Other: _____

In your own words, describe how injury/illness occurred:

_____

_____

_____

CONSENT FOR TREATMENT:

I CERTIFY THAT THE INFORMATION GIVEN BY ME IS CORRECT AND I HEREBY CONSENT TO AND AUTHORIZE THE PERFORMANCE OF TREATMENT AND/OR MEDICAL OR SURGICAL PROCEDURES OR SERVICES WHICH MAY BE CONSIDERED NECESSARY OR ADVISABLE BY THE PHYSICIAN (IF APPLICABLE). I GRANT TOTAL URGENT CARE AUTHORITY TO PERFORM NECESSARY EXAMINATION AND TESTING TO INCLUDE TESTS TO DETECT THE PRESENCE OF DRUGS AND/OR ALCOHOL IF REQUESTED BY MY EMPLOYER. I UNDERSTAND AND AGREE THAT ALL RESULTS WILL BE RELEASED TO MY EMPLOYER.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION: TOTAL URGENT CARE MAY DISCLOSE ALL OR ANY PART OF MY MEDICAL RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE TO TOTAL URGENT CARE FOR ALL OR PART OF ITS CHARGES, INCLUDING BUT NOT LIMITED TO, INSURANCE COMPANIES (HEALTH AND AUTO), WORKERS' COMPENSATION CARRIERS, OR MY EMPLOYER. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY BENEFITS FOR TREATMENT TO TOTAL URGENT CARE.

Patient or representative signature: _____ Date: _____

TOTAL URGENT CARE
Medicine the way it should be…friendly and affordable!!!

2120 Emmorton Park Road, Suite E
Edgewood, MD 21040
Tel: (410) 612-0374 Fax: (410) 612-9174

Acknowledgement of Offer to Receive or Receipt of Notice of Privacy Practices

Your Personal Health Information is Kept Private by Total Urgent Care

In accordance with the federal HIPAA regulation, we are required to follow very strict regulation as it pertains to your health information. Please see our Notice of Privacy Practices for more specifics on this issue.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Wanda Cox. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required in changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

I have been offered a copy of the Notice of Privacy Practices for **Total Urgent Care**.

Name of patient (please print clearly) **X**_____

Signature of Patient/Guardian **X**_____

Date **X**_____

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RESPIRATOR MEDICAL CLEARANCE FORM

Employee Name: _____ Social Security #: _____ Date: _____

DOB: _____ Age: _____ Company: _____ Contact: _____

Please check Type (s) of Respirator (s) to be used:

- ☐ Atmosphere-supplying respirator
- ☐ Open-circuit SCBA
- ☐ Supplied-air respirator
- ☐ Air-purifying (non-powered)
- ☐ Continuous-flow respirator
- ☐ Closed-circuit SCBA
- ☐ Combination air-lined and SCBA
- ☐ Air-purifying (powered)

Level of Work Effort: ☐ Light ☐ Moderate ☐ Heavy ☐ Strenuous

Extent of Usage:

- ☐ On a daily basis
- ☐ Occasionally - but more than once a week
- ☐ Rarely - or for emergency situations only

Length of Time of Anticipated Effort in Hours: _____

Special Work Considerations: (i.e. high places, temperature, hazardous material, protective clothing, etc.)

Company Safety Representative Telephone Number

Health Care Provider's Evaluation

Class (check one)

- ☐ No restrictions on respirator use
- ☐ Some specific use restrictions
- ☐ No respirator use permitted
- ☐ Need special frames for glasses if required to wear full-face respirator
- ☐ No contact lenses

Restrictions:

Note: Fit testing cannot be performed if facial hair is present across respirator seal areas (OSHA REG 29 CFR 1910.134)

Health care Provider Signature Date

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OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134 AppC

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Can you read: yes no

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (**Mandatory**) The following information must be provided by every employee who has been selected to use *any* type of respirator.

1. Today's Date	2. Your Name	3. Your Age
4. Your Social Security #	5. Your Job Title	6. Your Date of Birth
7. Sex (circle one) Male Female	8. Your Height _____ Ft. _____ in.	9. Your Weight _____ Lbs.
10. Phone # where you can be reached to discuss your answers: (_____) _____ -_____	11. The best time to call you at this number: _____a.m. p.m.	

12. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

13. Check the type of respirator you will use (you can check more than one category):
a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

14. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____
_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you **ever had** any of the following conditions?

a. Seizures (fits): Yes/No
b. Diabetes (sugar disease): Yes/No
c. Allergic reactions that interfere with your breathing: Yes/No
d. Claustrophobia (fear of closed-in places): Yes/No
e. Trouble smelling odors: Yes/No

3. Have you **ever had** any of the following pulmonary or lung problems?

a. Asbestosis: Yes/No
b. Asthma: Yes/No
c. Chronic bronchitis: Yes/No
d. Emphysema: Yes/No
e. Pneumonia: Yes/No
f. Tuberculosis: Yes/No
g. Silicosis: Yes/No
h. Pneumothorax (collapsed lung): Yes/No
i. Lung cancer: Yes/No
j. Broken ribs: Yes/No
k. Any chest injuries or surgeries: Yes/No
l. Any other lung problem that you've been told about: Yes/No

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath: Yes/No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
d. Have to stop for breath when walking at your own pace on level ground: Yes/No
e. Shortness of breath when washing or dressing yourself: Yes/No
f. Shortness of breath that interferes with your job: Yes/No
g. Coughing that produces phlegm (thick sputum): Yes/No
h. Coughing that wakes you early in the morning: Yes/No
i. Coughing that occurs mostly when you are lying down: Yes/No
j. Coughing up blood in the last month: Yes/No
k. Wheezing: Yes/No
l. Wheezing that interferes with your job: Yes/No
m. Chest pain when you breathe deeply: Yes/No
n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you **ever had** any of the following cardiovascular or heart problems?

a. Heart attack: Yes/No
b. Stroke: Yes/No
c. Angina: Yes/No
d. Heart failure: Yes/No
e. Swelling in your legs or feet (not caused by walking): Yes/No
f. Heart arrhythmia (heart beating irregularly): Yes/No
g. High blood pressure: Yes/No
h. Any other heart problem that you've been told about: Yes/No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes/No
b. Pain or tightness in your chest during physical activity: Yes/No
c. Pain or tightness in your chest that interferes with your job: Yes/No
d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No

7. Do you **currently** take medication for any of the following problems?

a. Breathing or lung problems: Yes/No
b. Heart trouble: Yes/No
c. Blood pressure: Yes/No
d. Seizures (fits): Yes/No

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No
b. Skin allergies or rashes: Yes/No
c. Anxiety: Yes/No
d. General weakness or fatigue: Yes/No
e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever lost** vision in either eye (temporarily or permanently): Yes/No

11. Do you **currently** have any of the following vision problems?

a. Wear contact lenses: Yes/No
b. Wear glasses: Yes/No
c. Color blind: Yes/No
d. Any other eye or vision problem: Yes/No

12. Have you **ever had** an injury to your ears, including a broken ear drum: Yes/No

13. Do you **currently** have any of the following hearing problems?

a. Difficulty hearing: Yes/No
b. Wear a hearing aid: Yes/No
c. Any other hearing or ear problem: Yes/No

14. Have you **ever** had a back injury: Yes/No

15. Do you **currently** have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No
b. Back pain: Yes/No
c. Difficulty fully moving your arms and legs: Yes/No
d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
e. Difficulty fully moving your head up or down: Yes/No
f. Difficulty fully moving your head side to side: Yes/No
g. Difficulty bending at your knees: Yes/No
h. Difficulty squatting to the ground: Yes/No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:_____
_____
_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No
b. Silica (e.g., in sandblasting): Yes/No
c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
d. Beryllium: Yes/No
e. Aluminum: Yes/No
f. Coal (for example, mining): Yes/No
g. Iron: Yes/No
h. Tin: Yes/No
i. Dusty environments: Yes/No
j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:_____
_____
_____

4. List any second jobs or side businesses you have:_____
_____

5. List your previous occupations:_____
_____

6. List your current and previous hobbies:_____
_____

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:_____

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No
b. Canisters (for example, gas masks): Yes/No
c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No
b. Emergency rescue only: Yes/No
c. Less than 5 hours per week: Yes/No
d. Less than 2 hours per day: Yes/No
e. 2 to 4 hours per day: Yes/No
f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. **Light** (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

b. **Moderate** (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. **Heavy** (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:_____
_____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):
_____
_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):
_____
_____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the second toxic substance:_____ _____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the third toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
The name of any other toxic substances that you'll be exposed to
while using your respirator:
_____
_____
_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

_____

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

_____ _____

PLHCP Signature **Date**

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Occupational History

Name:_____

Date of Birth: _____ **Reason for Exam:** □ Post Offer □ Annual □ Injury □ Other

Please check any of these items to which you have had exposures or needed medical treatment:

□ Asbestos	□ Dust	□ Vapors/Gases	□ Electroplating
□ Benzene	□ Radiation	□ Vibrations	□ Hazardous Waste
□ Blood/Body Fluids	□ PCB/PBB	□ Heat/Cold Exposure	□ Lead
□ Cadmium	□ Excessive Noise	□ Pesticides	□ Arsenic
□ Mercury	□ Methylene Chloride	□ Sandblasting	□ Solvents

□ Other (please specify): _____

If YES to any of the above, describe below including a complete description of the exposure, dates of occurrences, and the names of physicians who treated you. Also, please list place of employment if exposure occurred in a work environment.

---

1. Have you ever been injured on the job in any way?	□ Yes	□ No
2. Have you ever gotten sick in any way from something you worked with on the job?	□ Yes	□ No
3. Has your work ever caused problems with your joints (wrists, hands, knees, etc.) your back or skin?	□ Yes	□ No
4. Have you had any hobbies or jobs in which you use chemicals, metals, loud machines or tools, firearms, music, amplifiers, or other hazardous substances?	□ Yes	□ No
5. Have you ever claimed Workers' Compensation Benefits?	□ Yes	□ No
6. Have you ever terminated any job for health reasons?	□ Yes	□ No
7. Have you ever had to transfer from one job to another or change job duties for health reasons?	□ Yes	□ No
8. Have you ever been refused any job for health reasons?	□ Yes	□ No
9. Has a doctor ever placed restrictions on your lifting, bending, twisting, walking, standing, sitting, or using your hands, arms, or back?	□ Yes	□ No
10. Have you ever had a back injury or experienced back pain or back strain?	□ Yes	□ No
11. Have you ever had x-rays of your back?	□ Yes	□ No
12. Have you ever had surgery of any kind?	□ Yes	□ No
13. Have you ever been advised to have surgery that wasn't completed?	□ Yes	□ No
14. Are you currently under work restrictions?	□ Yes	□ No
15. Do you limit your personal activities due to pain, inability, or any other reason?	□ Yes	□ No
16. Have you ever received instructions on proper lifting?	□ Yes	□ No

If YES to any of the above, describe below including a complete description of the exposure, dates of occurrences, and the names of physicians who treated you. Also, please list place of employment if exposure occurred in a work environment.

_____

_____

I certify the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that knowingly making a false statement in this record may have consequences such as denial of workers' compensation claims, and withdrawal of offers of employment. I understand that Total Urgent Care will keep this medical history confidential.

Signature of Patient/Guardian: **X** _____ **Date:**_____

Signature of Clinician: _____ **Date:**_____

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Patient History

Injury/Urgent Care _____ Pre-Placement Exam _____ Periodic/Annual Exam _____ Private Exam _____ **Date:** _____

Employer _____ Occupation _____

Name _____ Date of Birth _____

Name of Primary Care Physician_____

PRESENT MEDICAL HISTORY

1. Why are you here today? _____
2. If you are here for an injury or illness, when did accident or illness occur?_____
3. Have you ever had similar symptoms before? ☐ YES ☐ NO If so, when?_____

PAST MEDICAL HISTORY

Have you now or ever had any of the following? (Please check all that apply)

	YES	NO		YES	NO		YES	NO
Mouth or Throat Disease	☐	☐	Fractures	☐	☐	Sinus Problems	☐	☐
Chest Conditions	☐	☐	Dislocations	☐	☐	Venereal Disease	☐	☐
Tuberculosis	☐	☐	Amputations	☐	☐	Are you pregnant?	☐	☐
Diabetes	☐	☐	Ganglions	☐	☐	Painful menstrual periods	☐	☐
Asthma/Hay Fever	☐	☐	Allergies	☐	☐	Foot Problems	☐	☐
Heart Problems/Disease	☐	☐	Epilepsy or Fainting Spells	☐	☐	Sleeping Problems	☐	☐
Stomach, Gall Bladder/			Skin Problems/Disease	☐	☐	Hearing/Vision Problems	☐	☐
Intestinal Trouble	☐	☐	Occupational Disease	☐	☐	Frequent Headaches	☐	☐
Kidney Trouble	☐	☐	Hemorrhoids	☐	☐	Frequent Colds	☐	☐
Rupture or Hernia	☐	☐	High Blood Pressure	☐	☐	Any claims for compensation		
Shortness of Breath	☐	☐	Back Pain/Injury	☐	☐	or Disability?	☐	☐
Varicose Veins	☐	☐	Knee Pain	☐	☐	Ever employed in Mine,		
Rheumatism or Arthritis	☐	☐	Wrist Pain	☐	☐	Quarry, Glass works, Foundry,		
Pneumonia/Pleurisy	☐	☐	Ulcers	☐	☐	Sandblasting, Chemical		
Chronic Cough	☐	☐	Nervous Disorders	☐	☐	Industry or exposed to		
Bronchitis	☐	☐	Abnormal Fatigue	☐	☐	asbestos products?	☐	☐
Frequent Indigestion	☐	☐	Poliomyelitis	☐	☐			

1. Any significant family medical conditions (If yes, please list)? _____
2. Show year and diagnosis of your last illness. _____
3. List ALL drugs or medications you use regularly: _____

   _____
4. When was your last tetanus shot? _____
5. ALLERGIES: List any allergies you may have. _____
6. VISION: Do you wear eyeglasses or contacts constantly? _____ Only for reading? _____
7. SOCIAL HISTORY: Do you have a history of drug use? _____
   Do you drink alcoholic beverages? _____ How many a week? _____
   Do you smoke cigarettes? _____ cigars? _____ pipe? _____
   How many per day? _____ For how long? _____
8. SURGERIES and/or HOSPITALIZATIONS: List dates and reasons for all surgeries and/or hospitalizations.

_____

MEDICAL RELEASE OF INFORMATION:

I HEREBY AUTHORIZE TOTAL URGENT CARE TO SEND A REPORT OF MY EXAMINATION TO THE COMPANY FOR WHICH THE EXAMINATION IS BEING CONDUCTED OR RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY. I FULLY RELEASE TOTAL URGENT CARE FROM ALL CLAIMS AND DAMAGES IN CONNECTION WITH FURNISHING THE REPORT TO THE SAID COMPANY OR INSURANCE COMPANY. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE DIRECTLY TO TOTAL URGENT CARE FOR ALL SERVICES RENDERED. MY SIGNATURE BELOW INDICATES THAT I HAVE TRUTHFULLY ANSWERED ALL QUESTIONS.

Employee/Patient Signature _____ Reviewing Staff Member _____