Penn Medicine
Chester County Hospital

Occupational Health Center
and Travel Medicine Program

Occupational Illness/Injury Initial Visit Form

Name: ______________________________ Today's Date: ______________

Social Security # : ________-________-________ Male _____ Female _____ Age______

Occupation/Job Title: ______________________________

Supervisor: ____________________ Department: ____________________

Date of Injury: ______ /______ /______ Time: ____________ AM / PM

Place (bldg/dept/floor etc.): ______________________________

Employer's Premises: ______ Yes ______ No If no, location: ____________________

Has this injury/illness been reported to your employer? ________ Yes ________ No
If yes, to whom?: ______________________________

What body part(s) was/were injured?: ______________________________

Describe exactly what you were doing and exactly how the injury occurred:

____
____
____

Have you received prior treatment for this injury/illness? ______ Yes ______ No
If yes, by whom?: ______________________________

Past Medical History
Do you have a history of previous injury to the same area?: ______ Yes ______ No
If yes, please describe (with dates): ______________________________
____
____

Are you under the care of a private physician? ______ Yes ______ No
For what conditions? ______________________________
If yes, Physician name: ____________________ Phone: ______-______-______
Address: ______________________________

I hereby consent to medical treatment for this injury/illness by The Occupational Health Center, to include any recommended diagnostic studies. I authorize release of information regarding this injury/illness to my employer, my employer's workers' compensation insurance carrier, and/or referral physician.

Employee Signature: ____________________ Date: ____________

Physician/Reviewer Signature: ______________________________