



# Request for Medical History

Injured Worker \_\_\_\_\_

Date of Injury \_\_\_\_\_

Employer \_\_\_\_\_

Current Date \_\_\_\_\_

Provide your medical history to ensure that you receive the proper medical care for your work injury.

Family Doctor / Primary Health Care Provider and Other Treating Doctors			
Name	Address	Phone	Condition Being Treated

Medications / Prescriptions			
Name	Description/Purpose	Dosage	Prescribing Doctor

Hospitalizations and Surgical Procedures			
Date(s)	Diagnosis/Treatment/Procedure	Doctor	Hospital

Please check to indicate if you have ever had any of the following conditions:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Back problems                      |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Stomach or peptic ulcer | <input type="checkbox"/> Knee, hip, or foot problems        |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Shoulder, elbow, or wrist problems |
| <input type="checkbox"/> High cholesterol     | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Carpal tunnel                      |
| <input type="checkbox"/> Thyroid disorder     | <input type="checkbox"/> Epilepsy (seizures)     | <input type="checkbox"/> Blood clotting disorders           |
| <input type="checkbox"/> Cancer - type: _____ | <input type="checkbox"/> Heart problems          | <input type="checkbox"/> Psychological condition            |

Fax the completed form to us at 844-761-8402 or email it to [claims@omahanational.com](mailto:claims@omahanational.com).

Signature \_\_\_\_\_

Date \_\_\_\_\_