



Request for Medical History

Injured Worker _____
Employer _____

Date of Injury _____
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.

Signature _____

Date _____