RMM ORTHOPAEDICS
Specializing in Arthroscopic Surgery and Sports Medicine

Workers' Compensation Patient Questionnaire

Name: _____ Date: _____

Age: _____ Sex: _____ **Right** / **Left** Handed (circle one)

Please fill out this entire questionnaire so that we may have the most accurate information concerning you injury.

CURRENT COMPLAINTS

What medical problem(s) is the doctor to see you for today? Please briefly describe your current complaints below.

1.

2.

3.

4.

5.

6.

INITIAL HISTORY OF INJURY

1. When did you first notice this medical problem? Date: _____
   (Whether you paid attention to this condition or not.)

2. What do you feel caused this condition? _____
   _____

3. Who was your employer at the time you noticed this condition?
   _____

4. How did the injury / accident / condition happen? Please be specific.
   _____
   _____
   _____

5. What were the immediate symptoms? _____
   _____

6. Did you finish what you were doing? **Yes / No**

7. Did you report the injury or problem? **Yes / No**
   If yes, when: _____ To whom: _____

HISTORY OF TREATMENT

1. When did you first see a doctor for this problem? _____

2. To which hospital or clinic were you taken? _____

3. Were you sent by your employer? **Yes / No**
   If yes, please indicate which tests were done below.

4. Name of the doctor you saw? _____
   What type of doctor? _____

5. Were tests done? **Yes / No**

   X-rays EMG Nerve Tests MRI Other:

2. What did the tests show? _____

3. What recommendations were made or what treatment was prescribed?
   _____

   a. Off work (dates): _____
   b. Hospitalized (give dates): _____
   c. Physical therapy (give dates, how often): _____
   d. Medication (give names): _____
   e. Casting: **Yes / No** Splinting: **Yes / No**
   f. Surgery (what kind, dates): _____
   _____

List <u>all</u> other doctors that you have seen for this injury:

Doctor's name: _____ Type of doctor: _____

Date last seen: _____ were tests done?_____

What did the test(s) show?_____

What treatment was given? _____

Hospitalized (dates): _____

Physical therapy (duration & frequency): _____

Medication (names): _____ Casting: **Yes / No** Splinting: **Yes / No**

Surgery [type(s) & date(s)]: _____

Which treatment helped? _____

Doctor's name: _____ Type of doctor: _____

Date last seen: _____ were tests done?_____

What did the test(s) show? _____

What treatment was given? _____

Hospitalized (dates): _____

Physical therapy (duration & frequency): _____

Medication (names): _____ Casting: **Yes / No** Splinting: **Yes / No**

Surgery [type(s) & date(s)]: _____

Which treatment helped? _____

Doctor's name: _____ Type of doctor: _____

Date last seen: _____ were tests done?_____

What did the test(s) show? _____

What treatment was given? _____

Hospitalized (dates): _____

Physical therapy (duration & frequency): _____

Medication (names): _____ Casting: **Yes / No** Splinting: **Yes / No**

Surgery [type(s) & date(s)]: _____

Which treatment helped? _____

Name of the doctor that you are <u>currently</u> seeing for this problem:

_____

Has your doctor released you to return to work? **Yes / No**
If **YES**, when were you released? _____

Were you released to full duty or light duty? **Full / Light**
If **LIGHT** duty, what were your restrictions? _____

_____

When did you actually return to work? _____ Are you still working? **Yes / No**
If **NO**, state reason:_____

Are you working at your same job? **Yes / No**

Are you working a different job? **Yes / No**

How is the work different from your previous job? _____

_____

WORK RECORD SINCE INJURY

Have you missed any work because of the injury? **Yes / No**

List all dates that you have not been working.

From _____ to _____ From _____ to _____

From _____ to _____ From _____ to _____

JOB DESCRIPTION

Job title at the time of your injury: _____

Employer at the time of your injury: _____

Hours worked per day _____Days worked per week _____ Overtime hours per week_____

Work duties (describe what you do during an average work day):

_____

_____

Maximum amount of weight that you would lift by yourself: _____

How many times per day would you have to lift this amount? _____

List any machines or tools that you routinely used at work: _____

_____

Check any activities required in the course of your work:

_____ Lift _____ Carry _____ Bend _____ Stoop

_____ Squat _____ Push _____ Pull _____ Climbing

_____ Walk _____ Sit _____ Stand

_____ Operate Equip. _____ Operate Equip. _____ Exposure

_____ Tools – Hand _____ Tools – Power _____ Repetitive Use

_____ Reach Forward _____ Reach Overhead _____ Awkward Positions

Number of years that you have worked for this employer: _____

Number of years that you have been in this line of work: _____

PAST MEDICAL HISTORY

Have you had previous injuries to any parts of your body involved in this claim? **Yes / No**
If yes, explain:

Have you ever had any other work related injuries? **Yes / No**
If yes, list dates and injuries:

Have you ever been hospitalized? **Yes / No**
If yes, list dates and reasons:

Have you ever had surgery? **Yes / No**
If yes, list date(s) and procedure(s):

List any motor vehicle accidents for which you received treatment:

_____
_____
_____

List current medications:

_____
_____
_____
_____

List any allergies to medications:
(Including adhesives, injectables or shellfish?)

_____
_____
_____
_____

Check any of the following conditions which you have now or had in the past:

_____ Diabetes _____ Thyroid Problems _____ Rheumatoid Arthritis

_____ Heart Attack _____ Stomach Ulcers _____ Tuberculosis

_____ Cancer _____ Kidney Problems _____ High Blood Pressure

_____ Stroke _____ Liver Disease

Please List any other medical conditions:

SOCIAL HISTORY

Check one of the following:

_____Married _____Single _____Divorced _____Separated _____Widow

Do you have any children? **Yes / No** If yes, how many? _____

Your date of birth: _____ Where you born? _____

Highest education completed: _____

Have you attended trade school? **Yes / No**

Hobbies: **Yes / No** If yes, what kind? _____

_____

Recreational Activities: _____

_____

_____

How much do you smoke? _____ For how long? _____

How much do you drink? _____ For how long? _____

Have you ever done any street drugs? **Yes / No**

If yes, what kind and how long ago? _____

Have you ever been in an alcohol or drug rehabilitation program? **Yes / No**

MILITARY HISTORY

_____ None

_____ Navy _____ Army _____ Marine Corps

_____ Air Force _____ Coast Guard _____ National Guard

Years of service: _____ Date of discharge: _____

PATIENT SIGNATURE:_____

DATE OF FORM COMPLETION:_____