WORKERS' COMPENSATION
PATIENT QUESTIONNAIRE

EXAMINING M.D.: ______________________
TYPE OF EXAM: ______________________
DATE OF EXAM: ______________________

• • • • • •

NAME ______________________ WCAB # ______________________
Address ______________________ Date of Birth ______________________
______________________ ZIP ________ Phone ( ) ______________________
Male: _____ Female: _____ SS# ______________________

• • • • • •

DATE OF INJURY ______________________ WORK RELATED? YES NO
Description of Injury: ______________________

EMPLOYER (at injury date) ______________________
Address ______________________
City, State, Zip ______________________
Job Title ______________________ No. of Years with employer: _____

• • • • • •

ATTORNEY ______________________ Phone ( ) ______________________
Address ______________________
City, State, Zip ______________________

• • • • • •

REFERRED BY ______________________ Phone ( ) ______________________
Address ______________________
City, State, Zip ______________________

• • • • • •

INSURANCE ______________________ Phone ( ) ______________________
Address ______________________
City, State, Zip ______________________
Claim # ______________________ Contact ______________________
CIRCLE ONE: Workers' Comp Auto Group Private Other

Interpreter Needed? YES NO Predominant Language ______________

Interpreter Name ______________________ History Taken By ______________

Company ______________________ Phone ( ) ______________

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Please fill out this form to the best of your ability, circling all questions either yes or no, or answering them in detail. Doing this will help for accuracy in the Doctor's report. Thank you.

PRESENT COMPLAINTS

Describe the physical problems that you are having at this time. (State LOCATION and AREAS that it spreads to)

#1. ____

____

When did it start? ______________________________

How long does it last? ______________________________

Describe it? (circle one) BURNING DULL ACHING STABBING SHARP THROBBING

Is it **CONSTANT** or **INTERMITTENT**? (circle one)

AGGRAVATING factors? ______________________________

RELIEVING factors? ______________________________

ACTIVITIES that it interferes with? ______________________________

____

#2. ____

____

When did it start? ______________________________

How long does it last? ______________________________

Describe it? (circle one) BURNING DULL ACHING STABBING SHARP THROBBING

Is it **CONSTANT** or **INTERMITTENT**? (circle one)

AGGRAVATING factors? ______________________________

RELIEVING factors? ______________________________

ACTIVITIES that it interferes with? ______________________________

____

#3. ____

____

When did it start? ______________________________
How long does it last? ______________________________
Describe it? (circle one) BURNING DULL ACHING STABBING
SHARP THROBBING
Is it **CONSTANT** or **INTERMITTENT**? (circle one)
AGGRAVATING factors? ______________________________
RELIEVING factors? ______________________________
ACTIVITIES that it interferes with? ______________________________

____

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PAST MEDICAL HISTORY

Please include approximate age where possible. Please circle those that apply.

Childhood diseases: Measles Mumps Chicken Pox Polio
Diptheria Whooping Cough Strep Throat
Rheumatic Fever German Measles Heart Murmur

Allergies: Asthma Hay Fever Hives Eczema
Foods: What? ______________________________
Drugs: What? ______________________________

Serious Accidents: (Be specific about age and injured body parts)
1. ______________________________
2. ______________________________
3. ______________________________

Major Adult Illnesses: Arthritis Pneumonia Tuberculosis
Diabetes Mellitus High Blood Pressure
Jaundice Heart Disease Kidney Disease

Family Physician Name: ____________________

Address: ____________________

City, State, Zip ____________________

PERSONAL HABITS

Sleep? How long per night? ____________________

Do you suffer from: Insomnia Nightmares Restlessness

Exercise? (type and amount of time spent) ____________________

____

Nutrition? Have you recently GAINED or LOST weight?

(circle one) Gained Lost

How many pounds? ____________

Circle any of the following that you use and state amount?

Caffeine How much per day? ____________________

Alcohol How much per day? ____________________

Tobacco How much per day? ____________________

Drugs/Medications What and how much per day? ____________________

Surgical Procedures: (Be specific about name of operation and date)

1. ______________________________

2. ______________________________

3. ______________________________

Other Hospitalizations: (Be specific about date and problem)

1. ______________________________

2. ______________________________

3. ______________________________

Previous Blood Transfusions: Yes No When? ______________

Foreign Travel: Yes No When? ______________

FAMILY HISTORY

Mark those that are found in your family:

	Mother	Father	Sis/Bro	Grandmother	Grandfather
Diabetes Mellitus	____	____	____	____	____
Tuberculosis	____	____	____	____	____
High Blood Pressure	____	____	____	____	____
Coronary Artery Disease	____	____	____	____	____
Epilepsy	____	____	____	____	____
Mental Illness	____	____	____	____	____
Allergies	____	____	____	____	____

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PATIENT PROFILE

Place of birth? ______________________________

Number of brothers/sisters ______________________________

Significant childhoold/adolescent/adult experiences? ______________

____

____

Education completed? ______________________________

Jobs held in the past? 1. ______________________________

2. ______________ 3. ______________

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