WORKERS' COMPENSATION
Examination Questionnaire

Please answer the following questions:

1) Name________________________Date of Injury:________ Is the injury work related?________
   If so, please explain:____
2) Are you currently working:__________ Have you worked or earned income since the injury date?________
3) Are you able to work?______________ If no, please explain: ___________________________

____

4) Prior to the injury, what activities or hobbies did you participate in?_________________________
5) Have you been able to participate in these activities or hobbies since your injury occurred? If not, why?____
   ____
   ____
   ____
6) What can't you do now that you could do before the injury? How have your circumstances changed? (Please be specific):____
   ____
7) List body parts injured (please be specific):____
   ____
8) Please list the limitations for each injured body part:______________________________________
   ____
   ____
   ____
   ____
9) Physician's comments:____
   ____
   ____

I certify that the above information is true and correct to the best of my knowledge. I understand it is important and necessary to give correct information for proper medical evaluation.

_______________________________________   ____________________

Patient' s Signature   Date

Oklahoma Sports Science and Orthopaedics, P.L.L.C.

Please complete this form and bring it with you on your visit

WORKERS' COMPENSATION ORTHOPAEDIC QUESTIONNAIRE

NAME: ______________________ EXAM DATE: ______________

AGE: ________ OCCUPATION: ______________ DOMINANT HAND: ____________

HEIGHT ________ WEIGHT ________

1. CHIEF COMPLAINTS:

   Part(s) of body injured: ______________________

2. HISTORY OF INJURY:

   Exact date of injury: ______________ Day of week: ______________

   Employer at time of injury: ______________________

   City and State where injury occurred: ______________________

   What were you doing and how did your injury occur? Please describe in detail: ______________

   Immediately following the injury what part(s) of your body hurt? ______________

   Describe the pain and problems following the injury: ______________

   Did you report the injury to your employer? YES NO If yes, when: ______________

   When did you first receive medical treatment for the injury (date)? ______________

   Name of the first doctor, clinic, and/or hospital that treated you: ______________

   Were x-rays taken? ________ Medication provided or prescribed? ______________

   Any physical therapy? ______________

   If x-rays were taken, what part of the body? ______________

   Name of medications: ______________

   If therapy, by whom was it given: ______________

   How often did you receive physical therapy? ______________ How long? ______________

   Describe any other treatment given since the injury: (i.e. cast, crutches, TENS unit, etc.) ______________

   Did this help? ________ If yes, describe improvement: ______________

(Please continue on reverse side.

Have you seen any other doctors, clinics, hospitals since the injury? ______

If yes, please list the names and dates from the first doctor you saw to the present:

Doctor	Specialty	Referred by:	City	Date first seen

Details (special tests, dates of hospitalization, dates of surgery, etc.) ______

Any new injuries or re-injuries since the date of the injury? ______

If yes, please describe and give date(s): ______

Have you missed any time from work as a result of your injury? ______

If yes, what was your last day worked? ______ Returned to work? ______

Were you ever told to return to modified duties? ______ If yes, did you? ______

When. ______ Is modified work available? ______

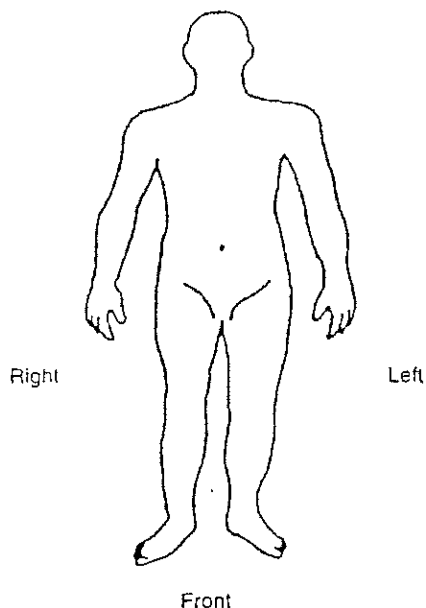
Are you currently working? ______ Same company? ______

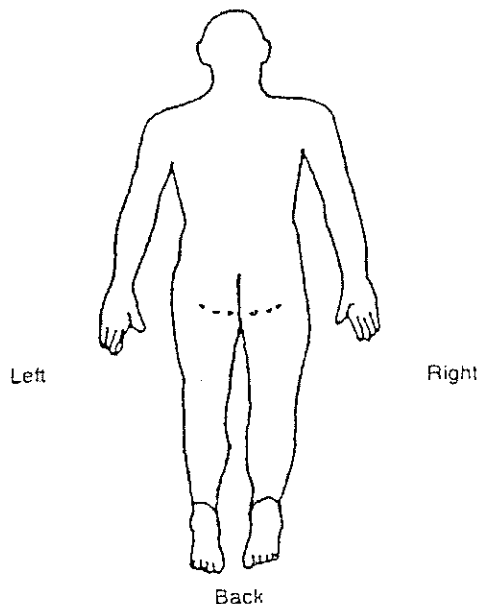
3. **PRESENT COMPLAINTS:** (describe in detail)

(Please continue next page.)

Indicate with the following symbols what kind of pain and where it is located:

Sharp pain - xxxxxxx   Dull pain - ooooooo   Numbness & tingling - use shading





Does the pain travel? (Please circle one): YES NO

Describe where it travels: ______________________________

____

What makes the pain worse? ______________________________

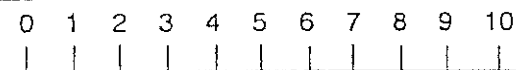
What makes the pain better? ______________________________

Where does it hurt the most? ______________________________

Describe your pain: DULL SHARP ACHING STABBING THROBBING BURNING

Other: ______________________________

On a scale of 1 to 10, 10 being the worse. Rate your pain.



4. **PRESENT TREATMENT:**

Are you still treating with the first physician who saw you for your injury? ______________________________

If no, name of current treating physician: ______________________________

Type of treatment you are receiving: ______________________________

Date of last visit with current treating physician: ______________________________

Date of last treatment (i.e. injection, physical therapy, medication):

Medications	How Often	For What

(Please continue on reverse side.)

Are you taking any medications now for any other reason? YES NO If yes, please give name, strength, how often you take it, and for what condition you are taking it.

Medications	How Often	For What

5. **OCCUPATIONAL HISTORY:**

Jobs held in the past five years:

	Job Title	Employer	From (month/year)	To (month/year)
1.				
2.				
3.				
4.				
5.				

6. **JOB DESCRIPTION:**

When the injury occurred, how many hours did you work per day? _________ Week _________ Overtime ___________

Occupation at the time of the injury: ____

List of job duties and physical requirements of your work at the time of the injury: ____________________

____

____

____

Work activities performed: Mark your usual work duties (at time of injury) with the following letters:

N = Not at all O = Occasionally F = Frequently C = Constantly

____Stand	____Kneel	____Reach	____Drive vehicle
____Walk	____Stoop	____Twist	____Detailed hand work
____Climb	____Push	____Bend	____Overhead work
____Squat	____Pull	____Lift	____a. 10 lbs. or less
			____b. 11 to 25 lbs.
			____c. 26 to 50 lbs.
			____d. 51 to 75 lbs.
			____e. 76 to 100 lbs.
			____f. over 100 lbs. With assistance?____

Total years performed this type of work? ____

Total number years worked for employer at time of injury? _______________ Date of hire: ________________

(Please continue next page.)

Work activities performed on present occupation (if different than listed on page 4). Mark your usual work duties with the following letters:

N = Not at all   O = Occasionally   F = Frequently   C = Constantly

____Stand	____Kneel	____Reach	____# lbs. lifted at one time
____Walk	____Stoop	____Twist	____Drive Vehicle
____Climb	____Push	____Bend	____Detailed Hand Work
____Squat	____Pull	____Lift	____Overhead Work

Other: ____________________

Total number of years performed at this type of work: ____________________

7. PAST MEDICAL HISTORY:

Have you had previous injuries or treatment to any parts of the body of which you are being seen for today?

Yes____No____If yes, please give dates and type of treatment. Please include sports injuries or auto accidents, etc.

____

____

____

____

Any other work related injuries not described above? ____________________

____

____

____

Did you recover from above injuries? __________ If no, please explain: ____________________

____

CHILDHOOD ILLNESSES: (Please circle those that apply)

Measles   Mumps   Chickenpox   Diphtheria   Whooping Cough   Strep Throat   Polio

Rheumatic Fever   Heart Murmur   Other: ____________________

ADULT ILLNESSES (Please circle those that apply.)

High Blood Pressure	YES	NO	When: ____________________
Bursitis/Tendinitis	YES	NO	What Joints: ____________________
Rheumatoid Arthritis	YES	NO	What Joints: ____________________
Osteoarthritis	YES	NO	What Joints: ____________________
Gout	YES	NO	When: ____________________
Diabetes	YES	NO	When: ____________________

(Please continue on reverse side.)

Thyroid Condition YES NO When: ____________________

Seizures YES NO When: ____________________

Liver Disease YES NO When: ____________________

Heart Attack YES NO When: ____________________

Stroke YES NO When: ____________________

Ulcers YES NO When: ____________________

Alcoholism YES NO When: ____________________

Other YES NO When: ____________________

8. SURGERIES/HOSPITALIZATIONS:

Have you ever had any surgeries? YES NO If yes, give type of surgery, date of surgery and part of body operated on: ____________________

____

Any other hospitalizations? YES NO If yes, please give dates and reason for hospitalization: ____________________

____

____

____

____

9. ALLERGIES: (Please circle those that apply.)

Asthma Hay Fever Hives Eczema Pollen

Allergies to any foods? Pleast list: ____________________

Allergies to any drugs? Please list: ____________________

Other allergies? Please list: ____________________

10. REVIEW OF SYSTEMS (Check any of the following problems you have now.)

Neurological

____Loss of consciousness

____Paralysis

____Changes in taste

____Tremors

____Gait disturbances

____Headaches

Respiratory

____Cough

____Flu

____Chest Pains

____Pneumonia

____Wheezing

____Blood clots in lung

____Pain with breathing

Cardiovascular

____Shortness of breath

____Palpitations

____Leg swelling

____Leg pain

____Pain in veins

____Shortness in breath when lying down

____Chest, arm, neck pain with exertion

(Please continue next page.)

General

____Weight loss

____Weight gain

____Fevers

____Chills

Musculoskeletal

____Joint pain

____Stiffness

____Fractures

____Joint swelling

____Muscle weakness

____Backache

Gastrointestinal

____Difficulty swallowing

____Heartburn

____Nausea/vomiting

____Blood in bowels

____Abdominal pain

____Jaundice

____Change in bowel habits

____Hepatitis

____Ulcer (type:____)

Genitourinary

____Loss of bladder control

____Urinary frequency

____Urination during sleep

____Painful urination

____Inability to urinate

____Dribbling

____Stones

____Discharges

____Pelvic pain

____Pain with intercourse

____Urinating in larger amounts than usual

____Venereal disease

____Sexual difficulties

11. FAMILY MEDICAL HISTORY

	Living	Deceased	Health Condition	Cause of Death	Age
Father	____	____	____	____	____
Mother	____	____	____	____	____
Brothers	____	____	____	____	____
Sisters	____	____	____	____	____

Please mark with the following (if found in your family).

	Father	Mother	Brother/ Sister	Grandfather	Grandmother
Diabetes	____	____	____	____	____
High blood pressure	____	____	____	____	____
Epilepsy	____	____	____	____	____
Mental illness	____	____	____	____	____
Allergies	____	____	____	____	____
Asthma	____	____	____	____	____
Arthritis	____	____	____	____	____

Signature ________________________ Date ____________

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Jimmy Conway has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

______________________________	______________________________
Signature of Patient	Signature of Parent or Guardian (if applicable)
______________________________	______________________________
Print Name of Patient	Print Name of Parent or Guardian

Dated:________________________