Use Patient Plate

UC Davis Medical Center
Department of Orthopaedic Surgery
Adult Reconstructive Surgery Unit

Today's Date

Workman's Compensation Questionnaire
All information in this questionnaire will be included in your medical record and will be held strictly confidential.

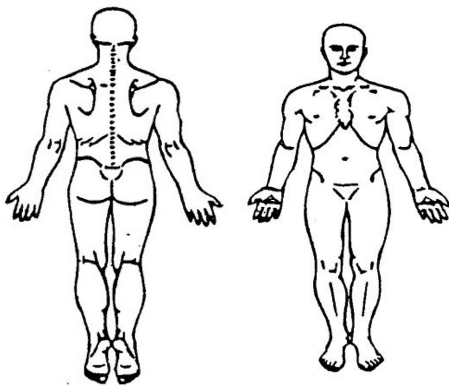
Name: M F
Last First MI

Age: Date of birth:
History of present illness

What part of your body is driving you to seek medical attention?
Hip Knee Other
Which side? Left Right

If you have an injury to the affected part, when did it occur?

How did this injury or accident happen?



0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Possible Pain

What makes your pain better? (rest, ice, heat, massage, medications)

What makes your pain worse? (activity, walking, running, bending, squatting)

What is the quality of your pain? (sharp, dull, ache, burning, other)

How many hours a day do you have this pain?

Do you have pain at rest? Yes No

Does the pain radiate to anywhere else? Yes No
If yes, where?

Do you have any of the following:
Swelling Numbness Popping or clicking Giving way
What limitations of your daily routine do you have due to this injury?

Have you injured this area prior to this injury? Yes No
If so, explain:

Occupational Information

What is your job title?

Did your injury occur at work? Yes No
Was it due to a single injury or due to a gradual problem?

Who was your employer at the time of the injury?

Please describe how the injury occurred.

Have you reinjured yourself since that time? Yes No
How would you describe the function of the injured body part BEFORE the injury?
Excellent Very Good Good Fair Poor (Constant Pain)

Name of the FIRST doctor that saw you after the injury
Date:

How did you get there? Driven Ambulance Other

What initial tests did you have? X-rays CT MRI EMG Bone Scan

What treatment was initially performed?

Were you taken off work? Yes No

Were you given modified duty? Yes No

Were you hospitalized? Yes No

Did you have physical therapy? Yes No

List other medical specialists that you have seen since the initial visit after your work related injury. Start with the first one after the initial evaluation and end with the most recent one.

Name	Date seen	Tests (EMG, CT, MRI, Bone Scan)	Treatment	Hospitalized? If yes, dates?	Surgery? If yes, what procedure?

Work status since time of injury?

On what approximate date did you return to work?

How many days of lost work did you have?

What date did you last work?

Do you have a new employer since your injury? Yes No

What are your usual duties?

What current work duties can you not perform as a result of your injury?

Do you have to lift? Yes No

If so, how much?

Do you have to kneel, bend or squat? Yes No

If so, how often?

Please list your previous employers in chronological order (most recent first)

Employer	Occupation	Dates

Do you use any walking aids? Yes No

If so, what do you use? Cane Walker Crutches Wheelchair

What percent of the time do you use your walking aids?

Do you use any braces? Yes No

Do you use any orthotics in your shoes? Yes No

If yes, please explain:

How far can you walk? Miles Yards Blocks

What treatments have you had for your current condition?

Have you had cortisone injections? Yes No

If yes, when and how often?

Have you had Viscosupplementation? (Synvisc, Hyalgan) Yes No

If yes, when and how often?

Do you take any anti-inflammatory medications Yes No

Do you take Chondroitin Sulfate and Glucosamine? Yes No

Do you have difficulty with stairs? Yes No Is the difficulty going up or going down?

Do you put both feet on each step? Yes No

Do you use a rail when going up and down stairs? Yes No

Can you put on your shoes and sock? Yes No

Can you cut your toenails yourself? Yes No

Please list any known medical conditions or problems	**Year of onset**

Please list surgeries that you have undergone	**Year performed**

Injuries, Car Accidents, or Broken Bones

Year	Incident	Treatment	Status	Work Related?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Please list any over the counter or prescribed medications

Drug Name	Strength or Dose	Taken when and how often?

Medication allergies: No known allergies OR

FAMILY HISTORY: Please list any illnesses of family members or cause of death if known.

	Age	Alive?	Deceased?	Describe illness or cause of death if known
Mother				
Father				
Sisters				
Brothers				
Children				

Review of Systems

Check if you have had, or currently have any of the following symptoms and the date of onset

Symptom	Date on onset	Symptom	Date of onset
Fevers		Phlebitis	
Chills		AIDS	
Night sweats		Hepatitis B	
Rashes/frequent itching		Hepatitis C	
Sores that don't heal		Previous deep vein	
Hearing loss		Transient ichemic	
Nasal problems		Seizures	
Difficulty swallowing		Calf pain on exertion	
Thyroid problems		Easy bruisability	
Weight loss		Swollen nodes	
Weight gain		Paralysis	
Excessive sweating		Weakness	
Tremor		Numbness	
Chest pain		Tingling in arms	
Shortness of Breath		Painful urination	
Cough		Frequent urination	
Enlarged heart		Bloody urine	
Irregular heart beat		Bleeding ulcers	
Heart murmur		Hiatal hernia	
Wheezing		Frequent indigestion	
Vein problems		Colitis	
Others:			

Social and Activity History: This information may impact your health insurance. If you have any concerns about this, please leave the information blank and discuss it verbally with your physician to ensure confidentiality.

			How many per day?	**How many years?**
Cigarettes	Yes	No		
Cigars	Yes	No		
Pipe	Yes	No		
Alcohol	Yes	No		

Illicit Drugs — Are you currently using or have you used any illicit drugs such as methamphetamine or cocaine? Yes No

Have you ever used intravenously injected drugs such as heroin?
Yes No

Highest Grade of School Completed — Elementary High School College Post-Graduate

Current Occupation

Marital Status Single Married Divorced Widowed Other

Hobbies/Activities/Sports

How many hours a week do you perform these activities?

Physician Name

Date of Review

Physician Signature

Physical Examination (To be filled out by an MD)						
General	Standing Alignment Varus Valgus Deg					
App	Gait Trend Antalgic Side					
Hip	Knee					
TTP	Yes No Location	Effusion	Standing Alignment			
ROM (Extension)	TTP					
Flexion	Extension	ABD	Medial	Lateral		
ADD	ER	IR	Stability			
ROM (90 Flexions)	Varus	Valgus				
Flexion	Extension	ABD	Lachman	Post Drawer		
ADD	ER	IR	Patellofemoral Joint			
Anterior Apprehension	Posterior Apprehension	Crepitance	Apprehension			
LLD	Eql	R>L	L>R	cm?	Flexion	Extension
Vascular DP PT						
Sensory	DTR	KJR R L	AJR R L			
Motor Q JS TA GS EHL FHL						