INTERNAL MEDICINE QUESTIONNAIRE

Name: ______________________________

Date: ______________________________

Height: __________ Weight: __________ Age: ______ Right-handed? ______ Left-handed? ______

Date of Injury __________.

Briefly describe how you were injured, including which body parts were injured. If there is more than one injury, please provide dates for all of them separately, as well as the body parts involved.

____

____

____

____

____

OCCUPATIONAL HISTORY & JOB DESCRIPTION

The following questions relate specifically to the job that you were performing at the time of your injury for which you are being examined today. If you have subsequently switched employment or had a change from your duties that you were performing at the time of your injury, please <u>do not</u> describe your new duties in this section. **Again, this section relates specifically to those duties you were performing at the time of your injury.**

1. The injury you are being examined for today occurred while you were employed by:

2. What was your occupational title for the employer named above?

3. What were the duties of your job? Please list your general job tasks. Only a brief description of each task is necessary. *(For example, a secretary might list: a) type; b) take dictation; c) operate a phone system.)*

   Your job duties:

   (a) ______________________________

   (b) ______________________________

   (c) ______________________________

   (d) ______________________________

ACTIVITY	TIME SPENT			
	None at All	Up to 1/3 of Workday	Up to 2/3 of Workday	More Than 2/3 of Workday
Twisting (your torso or lower back)				
Walking				
Walking on uneven terrain				
Simple (or light) grasping with hands				
Fine manipulative hand motions (e.g., circuit board work, typing, etc.)				
Pushing and pulling				
Reaching overhead				
The use of foot controls				

a) What was the maximum amount lifted in your job? ______________________

b) How many times a day were you required to lift this weight? ______________________

c) What type of floor surface did you work on while at work?

Cement ____
Wood ____
Carpet ____
Brick ____
Uneven terrain ____
Tile ____
Other ______________________

7. Please list all injuries, by body part and date, which you had while employed by the employer listed in Question 1. If possible, also indicate the amount of time you lost from work, if any, including the time lost due to the injury for which you are being examined today.

a) ______________________
b) ______________________
c) ______________________
d) ______________________
e) ______________________

PRIOR EMPLOYMENT

8. Last Prior Employer. Respond to the following questions beginning with the employer you had prior to the employer you were working for at the time of your injury:

a) Name of last prior employer ______________________

b) Location ______________________________

c) Occupation/work duties ______________________________

d) Period of prior employment: From ______________ To ______________

9. Second to Last Prior Employer. Respond to the following questions regarding your employer prior to the one named in Question 8 above:

a) Name of second to last prior employer ______________________________

b) Location ______________________________

c) Occupation/work duties ______________________________

____

d) Period of prior employment: From ______________ To ______________

10. Third to Last Prior Employer. Respond to the following questions regarding your employer prior to the one named in Question 9 above:

a) Name of third to last prior employer ______________________________

b) Location ______________________________

c) Occupation/work duties ______________________________

____

d) Period of prior employment: From ______________ To ______________

SIMULTANEOUS EMPLOYMENT

11. Did you work for any other employer at the same time that you were working for the employer named originally in Question 1?

Yes _____ No _____

If no, go on to question number 12.

If yes, then respond to the following:

a) Name of employer ______________________________

b) Location ______________________________

c) Occupation/work duties ______________________________

d) Hours worked per week ______________________________

e) Dates of employment ______________________________

12. Have you worked anywhere <u>after</u> the employer originally named in Question 1?

Yes ______ No ______

If no, go on to question number 14.

If yes, then respond to the following:

a) Are you currently employed there? Yes _______ No _______

b) By whom are you currently employed? ______________________________

c) Where is your current employer located? ______________________________

d) What are your current occupation/work duties? ______________________________

e) When did your current employment begin? ______________________________

13. Respond to the following questions beginning with your first employer <u>after</u> the injury for which you are being examined today.

a) Name of first subsequent employer ______________________________

b) Location of employment? ______________________________

c) Occupation/work duties? ______________________________

d) Period of subsequent employment: From ________________ To ________________

a) Name of second subsequent employer? ______________________________

b) Location of employment? ______________________________

c) Occupation/work duties? ______________________________

d) Period of subsequent employment: From ________________ To ________________

CURRENT COMPLAINTS AND/OR TREATMENT

14. List or describe the main symptoms and problems for which you are being evaluated today:

15. When and how did this (or these) problem(s) start?

Do you do any of the following activities?					
	Yes	No		Yes	No
Driving			Housecleaning		
Walking			Shopping		
Cooking			Physical exercise		

Can you:	Normal	Limited	Not at all
Bend?			
Stoop?			
Walk? *			
Sit? *			
Climb?			
Lift?			

* If these activities are limited, please describe your limitations?:			
Walk	Blocks	Miles	Minutes
Sit			Minutes
Lifting			Pounds
Description of limitation:			

Describe the maximal physical activities you engage in:

Has anyone assisted you with this form?	Yes	No
If yes, whom?		

16. List all the physicians who you've seen for this problem:

Name	Specialty	Location of Doctor	Date	Who Referred You?

17. Check all the tests you have had related to this treatment:

___ EEG
___ ENG
___ Hearing test
___ X-rays of: ____________________
___ Myelogram
___ Spinal tap
___ Blood tests
___ MRI of: ____________________
___ Nerve tests (EMG/NCV)
___ Urine tests
___ Psychological testing
___ CT scan of: ____________________
___ Endoscopy
___ Other: ____________________

18. Check all treatments you have had:

___ Physical therapy
___ Surgery
___ TENS (nerve stimulator)
___ Shots or injections
___ Chiropractic
___ Biofeedback
___ Traction
___ Hypnosis
___ Acupuncture
___ Braces or corset
___ Pain management
___ Vocational rehabilitation
___ Medications
___ Other ____________________

19. Who is your current treating doctor for this problem?

20. What is the date of your last visit to this doctor?

21. What treatment are you currently receiving?

22. Have you ever had the same or similar symptoms in the past?

Yes _______ No _______

If yes, please describe when and briefly give the circumstances connected with the prior symptoms.

____

____

REVIEW OF SYMPTOMS

Please check those symptoms that apply:

Symptom	Now	In Past	Symptom	Now	In Past
Tension headache			Uncontrollable movements		
Migraine headache			Tremors		
Neck pain			Muscle tics/twitches		
Blurred vision			Muscle cramps		
Double vision			Muscle pain		
Failing vision			Muscle weakness		
Spots before eyes			Muscle shrinkage		
Vision blackouts			Muscular paralysis		
Hiccups			Poor coordination		
Excessive yawning			Poor balance		
Hoarseness of voice			Falling spells		
Ringing in ears			Low back pain		
Lightheadedness			Mid-back pain		
Poor equilibrium			Hip/buttock pain		
Dizziness/vertigo			Numbness/tingling		
Fainting spells			Burning sensations		
Convulsions/seizures			Joint pain/stiffness		
Blackouts			Joint swelling		
Cold fingers and toes			Eczema		
Blood in stool			Skin rash		
Hemorrhoids			Easy bruising		
Constipation			Hard to stop bleeding		
Burning urination			Frequent nausea		
Frequent urination			Frequent vomiting		
Blood in urine			Heartburn/indigestion		

Problems with:	Now	In Past
Undesired weight loss		
Undesired weight gain		
Shortness of breath		
Chest pain		

Difficulties with:	Now	In Past
Smelling		
Tasting		
Chewing		
Speaking		
Swallowing		
Reading		
Writing		
Memory		
Understanding		
Forgetfulness		
Thinking clearly		
Concentration		
Periods of confusion		
Chronic fatigue		
Loss of interest		
Excessive drowsiness		
Trouble sleeping		
Feeling depressed		
Feelings of hopelessness		
Thoughts of suicide		

Problems with:	Now	In Past
Controlling bowels		
Controlling urination		
Obtaining an erection		

Difficulties with:	Now	In Past
Recurrent fears		
Worry about health		
Panic attacks		
Hyperventilation		
Frequent crying		
Feeling persecuted		
Hearing voices		
Hallucinations		
Chronic worry		
Irritability		
Moodiness		
Feeling stress		
Inability to relax		
Overreacting emotionally		
Explosive temper		
Change in personality		
Nervous breakdown		
Drug use		
Heavy alcohol use		
Suicide attempts		

FAMILY HISTORY

List any family members who have or have had:			
Epilepsy or seizures		High blood pressure	
Neuromuscular disease		Stroke	
Nervous or medical conditions		Chronic pain	
Alcoholism		Other (describe)	
Cancer		Other (describe)	
Diabetes		Other (describe)	

MEDICAL HISTORY

Has a doctor ever said you had any of the diseases or conditions listed below?
If yes, are you receiving treatment now?

Disease/Condition	Now	Treatment	Disease/Condition	Now	Treatment
Arthritis			Heart disease		
Gout			Heart murmur		
Asthma			Gallbladder		
Allergies			Cirrhosis		
Lung disease			Hepatitis		
Tuberculosis			Colon/bowel disease		
Emphysema			Cancer or tumor		
Anemia			Stomach problems/ulcer		
Thyroid disease			Venereal disease		
Diabetes			Other diseases or conditions:		
High blood pressure					

Check any of the following operations you have had:					
Tonsils		Stomach		Ovary	
Appendix		Gallbladder		Breast	
Hernia		Kidney		Thyroid	
Hemorrhoids		Tubal ligation		Laminectomy (neck)	
Colon		Hysterectomy		Laminectomy (back)	

Other diseases, conditions, or operations you have undergone:

SUBSTANCE USE

Please indicate whether or not you use the following items and, if yes, what type and quantity:

Current Use					Past Use	
Substance	**Yes**	**No**	**Type**	**Amount per day**	**Yes**	**No**
Tobacco						
Alcohol						
Coffee						

HOSPITALIZATIONS

List all hospitalizations other than those for operations:

Year	Reason

MEDICATIONS

List all medications you take. Include vitamins, hormones and non-prescription drugs.

Name	Dose	How often?

List all medications to which you are allergic:

Were you ever denied medical treatment? ( ) Yes ( ) No

If yes, explain why treatment was denied:____

____

____

TRAUMAS/INJURIES

List all injuries (broken bones, sprains, concussions, lacerations, etc.):

Auto Accident	Other	Year	Type of injury	Treatment

Industrial injuries:

Date	Type of injury (Body parts involved)	Outcome

Have you ever been involved in a lawsuit or any type of legal action having to do with accidents or health matters?

YES ______ NO ______

If yes, please list all such occurrences:

Year	Description	Outcome

ACTIVITY LEVEL

List all hobbies, physical activities and interests	Now	Prior to injury

Epworth Sleepiness Scale

Name: ______________________________

Date: ______________________________

Your age: (Yr) ______________ Your sex: ❑ Male ❑ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:

0-10	Normal range
10-12	Borderline
12-24	Abnormal

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