Patient Questionnaire for Fred V. Orcutt, M.D.

Dear Patient:

You have been scheduled for an evaluation which will be conducted at my office.

The report, which I shall prepare, will be a fair and objective assessment of your physical condition and an evaluation of those effects upon you, which your injury may have caused. It is important that the report include information about your entire health history, which will assist in evaluating the effect of the injury upon you. For this reason, it would be very helpful if you would be kind enough to fill out this Questionnaire as completely and accurately as possible. I shall attest to the truth and objectivity of this report under penalty of perjury. For this reason and because of my personal and medical ethics, the content and opinions of this report are not influenced by the party who may have ordered the report.

It is most important that I be in possession of as much information as can be provided to write the best possible report. Medical records, imaging studies, job assessment and other reports have been provided. You, the patient, are the source of the most important and most credible information. In filling out this form, accuracy and completeness are most important. For these reasons, I would appreciate if you would fill in this Questionnaire as completely as possible.

Imaging studies, such as **x-rays, MRIs** and **CT scans**, represent the most important information, which I very much need to prepare a fair and complete report. It is very much in your interest that I am provided with these important studies as films, not only reports. **If you could bring these studies with you**, it would be most helpful.

Thank you in advance for your cooperation.

Fred V. Orcutt, M.D.

PATIENT INFORMATION:

1. Full legal Name: _____, _____ _____
   Last First Middle

2. Maiden or other names: _____, _____ _____
   [Names used in medical records] Last First Middle

3. Date of birth: _____ _____ 19____ Gender: M F
   Month Day Year (Circle)

4. Present Age: _____ years old

5. Social Security Number: _____-_____-_____

6. Weight before injury: _____ pounds

7. Current height: _____ feet; _____ inches; _____ total inches

8. Current weight: _____ pounds

9. Which hand do you write with: (Circle one) Right Left

EMPLOYER INFORMATION:
At time of injury

_____ (____)_____-_____
Company Telephone number

_____
Street Address

_____, _____ _____
City State Zip Code

CHIEF COMPLAINT:

In your own words, write the important problems, which you are experiencing, that are related to your injury.

Patient's statement:

"_____

_____

_____

_____"

JOB DESCRIPTION AT TIME OF INJURY:
What is your job title?_____

Hours worked per day: _____ hours. Days per week: _____ days.

Describe a typical workday: _____

_____

_____

_____

Maximum lifted: _____ pounds. How often?_____

Average lifted: _____ pounds. How often?_____

HISTORY OF INJURY: In your own words, write about the injury.

Place of injury (location or address):_____

_____

What were you doing just before the injury?_____

_____

_____

_____

Date and Time of injury: _____ (Month) _____, _____ (Day, Year); _____ (Time) AM / PM (Circle One)

Did you report the injury to your employer or supervisor: (Circle One) Yes No

When did you report injury to employer? _____ (Month) _____, _____ (Day, Year); _____ (Time) AM / PM (Circle One)

Name of person, to whom you report the injury: _____

Witness to injury (if any):_____

_____

What happened to cause the injury?_____

_____

_____

_____

What injuries did you sustain (what body parts and how injured)?_____

_____

_____

_____

Did your symptoms come on at the time of injury? (Circle One) Yes No

If no, describe when and over what period they occurred:_____

_____

_____

_____

If no, when did you realize that you were injured? Date: _____ (Month) _____ (Day), _____ (Year)

Explain:_____

_____

_____

What happened after the injury? Could you walk? Where did you go?_____

_____

_____

_____

Date disability started (Any time off work?): _____ (Month) _____ (Day), _____ (Year)

Has disability ended? (Circle One) Yes No If yes, date disability ended: _____ (Month) _____ (Day), _____ (Year)

HISTORY OF TREATMENT AND COURSE:

Initial Treatment:

When were you first treated for your injury? _____ (Month) _____ (Day), _____ (Year)

Did your employer send you for initial treatment? (Circle One) Yes No

Did you seek initial treatment on your own? (Circle One) Yes No

Were you taken to an emergency room or hospitalized? (Circle One) Yes No

Name of hospital / emergency room: _____ City: _____

Were you admitted? (Circle One) Yes No Date discharged: _____ (Month) _____ (Date), _____ (Year)

Name of treating doctor: _____

Describe treatment, tests and x-ray studies: _____

_____

Did the doctor say what was wrong with you (diagnosis)? (Circle One) Yes No

Explain diagnosis: _____

_____

_____

Were you told that more treatment was necessary? (Circle One) Yes No

Did the doctor restrict or modify your work activities? (Circle One) Yes No

Were you told to stay off work? (Circle One) Yes No

Please list all doctor, M.D.'s, D.O.'s, chiropractors, etc., whom you have seen (in the order you saw them):

Doctor/Facility #1: _____ City: _____

Degree and specialty: _____

Describe treatment and/or tests: _____

Did the doctor state a diagnosis: (Circle One) Yes No Explain: _____

Date treatment started: _____ (Month) _____ (Date), _____ (Year) Stopped: _____ (Month) _____ (Date), _____ (Year)

Number of treatment: _____ Length of treatments: _____

Did you get better? (Circle One) Yes No Explain:_____

_____

Are you still treating with this doctor? (Circle One) Yes No
If yes, how often? _____ times per week.

Did this doctor take you off work? (Circle One) Yes No

If yes, disability started: _____ _____, _____ Stopped:_____ _____, _____
Month Date Year Month Date Year

Did the doctor modify work activities? (Circle One) Yes No

Did the doctor say you needed more treatment? (Circle One) Yes No

Did the doctor prescribe physical therapy? (Circle One) Yes No

Did the doctor refer you to another physician? (Circle One) Yes No

Explain to whom and why?_____

Doctor/Facility #2:_____ City:_____

Degree and specialty:_____

Describe treatment and/or tests:_____

Did the doctor state a diagnosis: (Circle One) Yes No Explain:_____

Date treatment started: _____ _____, _____ Stopped:_____ _____, _____
Month Date Year Month Date Year

Number of treatment:_____ Length of treatments:_____

Did you get better? (Circle One) Yes No Explain:_____

_____

Are you still treating with this doctor? (Circle One) Yes No
If yes, how often? _____ times per week.

Did this doctor take you off work? (Circle One) Yes No

If yes, disability started: _____ _____, _____ Stopped:_____ _____, _____
Month Date Year Month Date Year

Did the doctor modify work activities? (Circle One) Yes No

Did the doctor say you needed more treatment? (Circle One) Yes No

Did the doctor prescribe physical therapy? (Circle One) Yes No

Did the doctor refer you to another physician? (Circle One) Yes No

Explain to whom and why?_____

Doctor/Facility #3:_____ City:_____

Degree and specialty:_____

Describe treatment and/or tests:_____

Did the doctor state a diagnosis: (Circle One) Yes No Explain:_____

Date treatment started: _____ _____, _____ Stopped:_____ _____, _____
Month Date Year Month Date Year

Number of treatment:_____ Length of treatments:_____

Did you get better? (Circle One) Yes No Explain:_____

_____

Are you still treating with this doctor? (Circle One) Yes No
If yes, how often? _____ times per week.

Did this doctor take you off work? (Circle One) Yes No

If yes, disability started: _____ _____, _____ Stopped:_____ _____, _____
Month Date Year Month Date Year

Did the doctor modify work activities? (Circle One) Yes No

Did the doctor say you needed more treatment? (Circle One) Yes No

Did the doctor prescribe physical therapy? (Circle One) Yes No

Did the doctor refer you to another physician? (Circle One) Yes No

Explain to whom and why?_____

Doctor/Facility #4:_____ City:_____

Degree and specialty:_____

Describe treatment and/or tests:_____

Did the doctor state a diagnosis: (Circle One) Yes No Explain:_____

Date treatment started: _____ _____, _____ Stopped:_____ _____, _____
Month Date Year Month Date Year

Number of treatment:_____ Length of treatments:_____

Did you get better? (Circle One) Yes No Explain:_____

_____

Are you still treating with this doctor? (Circle One) Yes No
If yes, how often? _____ times per week.

Did this doctor take you off work? (Circle One) Yes No

If yes, disability started: _____ (Month) _____ (Date), _____ (Year) Stopped: _____ (Month) _____ (Date), _____ (Year)

Did the doctor modify work activities? (Circle One) Yes No

Did the doctor say you needed more treatment? (Circle One) Yes No

Did the doctor prescribe physical therapy? (Circle One) Yes No

Did the doctor refer you to another physician? (Circle One) Yes No

Explain to whom and why? _____

If more doctors/facilities, use additional sheet.

List major imaging studies done (such as MRIs, CT scans, EMGs, etc.) with locations:

Study: _____ _____ (Location) _____ (Month) _____ (Day), _____ (Year)

Study: _____ _____ (Location) _____ (Month) _____ (Day), _____ (Year)

Study: _____ _____ (Location) _____ (Month) _____ (Day), _____ (Year)

Study: _____ _____ (Location) _____ (Month) _____ (Day), _____ (Year)

Study: _____ _____ (Location) _____ (Month) _____ (Day), _____ (Year)

Have you treated yourself? (Circle One) Yes No Explain: _____

Are you taking any pain or other medicine due to the injury? (Circle One) Yes No

If yes, give medicine name, dosage, frequency and effect:

Medicine: _____ (Name) _____ (Dose) _____ (Frequency) _____ (Perceived Effect (Good / None / Bad))

Medicine: _____ (Name) _____ (Dose) _____ (Frequency) _____ (Perceived Effect (Good / None / Bad))

Medicine: _____ (Name) _____ (Dose) _____ (Frequency) _____ (Perceived Effect (Good / None / Bad))

Medicine: _____ (Name) _____ (Dose) _____ (Frequency) _____ (Perceived Effect (Good / None / Bad))

Medicine: _____ (Name) _____ (Dose) _____ (Frequency) _____ (Perceived Effect (Good / None / Bad))

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

If yes, explain why treatment was denied:_____

_____

HISTORY OF OTHER INJURIES:

List injuries that you have had from childhood until now. Include date or year, whether work or auto related, treatment and any remaining problems or deformities:

1. Injury:_____ Date:_____

   Work related: (Circle One) Yes No Auto or motorcycle accident: (Circle One) Yes No

   Treatment:_____

   Full recover: (Circle One) Yes No Explain:_____

   _____

2. Injury:_____ Date:_____

   Work related: (Circle One) Yes No Auto or motorcycle accident: (Circle One) Yes No

   Treatment:_____

   Full recover: (Circle One) Yes No Explain:_____

   _____

3. Injury:_____ Date:_____

   Work related: (Circle One) Yes No Auto or motorcycle accident: (Circle One) Yes No

   Treatment:_____

   Full recover: (Circle One) Yes No Explain:_____

   _____

4. Injury:_____ Date:_____

   Work related: (Circle One) Yes No Auto or motorcycle accident: (Circle One) Yes No

   Treatment:_____

   Full recover: (Circle One) Yes No Explain:_____

   _____

5. Injury:_____ Date:_____

   Work related: (Circle One) Yes No Auto or motorcycle accident: (Circle One) Yes No

   Treatment:_____

   Full recover: (Circle One) Yes No Explain:_____

   _____

CURRENT RELEVANT SYMPTOMATOLOGY:

State what you can (or cannot) do at this time:

1. How long can you **sit** before you must get up? _____ hours
   a. Can you **squat**? (Circle One) Yes No
2. How long ca you **stand** in one position? _____ hours
   a. Can you **bend** to pick up something from the floor? (Circle One) Yes No
   b. Can you **kneel**? (Circle One) Yes No
3. How far can you **walk**? (Give distance) _____
   a. How much weight can you **carry**? _____ lbs.
   b. Can you **crawl** for ten feet? (Circle One) Yes No
4. **Climbing**
   a. Can you **climb** one flight of stairs? (Circle One) Yes No
   b. Can you **climb** a ten foot ladder? (Circle One) Yes No
   c. Could you **run** 25 feet? (Circle One) Yes No
5. **Lifting**
   a. How many pounds can you **lift** from ground to waist? _____ lbs.
   b. How many pounds could you **lift** above your shoulders? _____ lbs.
   c. Can you **twist** while pulling? (Circle One) Yes No
   d. Can you **push**? (Circle One) Yes No
   e. Can you **pull**? (Circle One) Yes No
6. **Hand Function**
   a. Do you have trouble **feeling** with your fingers? (Circle One) Yes No
   b. Can you **grip** a hammer? (Circle One) Yes No
   c. Can you hold a pen (**pinch**)? (Circle One) Yes No
   d. Can you **operate** hand or foot controls? (Circle One) Yes No

Patient describes daily pain as follows:_____

_____

_____

_____

JOB HISTORY:

The patient lists the following employers, by whom he was employed, starting with most recent employer:

1. Employer: _____ From:_____ To:_____
   Describe the job:_____
2. Employer: _____ From:_____ To:_____
   Describe the job:_____
3. Employer: _____ From:_____ To:_____
   Describe the job:_____
4. Employer: _____ From:_____ To:_____
   Describe the job:_____
5. Employer: _____ From:_____ To:_____
   Describe the job:_____

PAST MEDICAL HISTORY:

Childhood Illnesses: List any serious illnesses you had as a child:_____

_____

Adult Illnesses: List any serious illnesses you had as an adult:_____

_____

Present medication taken regularly: List name(s) of medicines, the does (in mg) and number of times per day the medicine is taken:

Medicine:_____ _____ _____
Name Dose Times per day

Medicine:_____ _____ _____
Name Dose Times per day

Medicine:_____ _____ _____
Name Dose Times per day

Medicine: _____ _____ _____
Name Dose Times per day

Medicine: _____ _____ _____
Name Dose Times per day

Surgeries: List names of surgeries, where done and when:

Name of Surgery: _____ _____ _____
Location Date

Name of Surgery: _____ _____ _____
Location Date

Name of Surgery: _____ _____ _____
Location Date

Name of Surgery: _____ _____ _____
Location Date

Name of Surgery: _____ _____ _____
Location Date

Hospitalizations: List any time you have been an inpatient in a hospital with hospital name, dates of admission and discharge, and reason:

Name of Hospital: _____ ___/___/___ to ___/___/___
Admission date Discharge date

Name of Hospital: _____ ___/___/___ to ___/___/___
Admission date Discharge date

Name of Hospital: _____ ___/___/___ to ___/___/___
Admission date Discharge date

Name of Hospital: _____ ___/___/___ to ___/___/___
Admission date Discharge date

Name of Hospital: _____ ___/___/___ to ___/___/___
Admission date Discharge date

FAMILY HISTORY: List any family members who have the following diseases:

Cancer (location): _____

Diabetes: _____

Heart disease: _____

Hypertension: _____

REVIEW OF SYSTEMS:

HENT: Have you had: (Circle any that apply) Frequent, severe headaches? Nose bleeds? Hoarseness?

Eyes: Do you wear: Glasses: (Circle one) Yes No Contact lenses: (Circle one) Yes No

Any eye disease? (Circle any that apply) Glaucoma? Detached retina? Cataracts? Other:_____

Respiratory: Have you had: (Circle any that apply) Shortness of breath? Chronic cough? Asthma?

Bronchitis? Cough up blood? Pneumonia? Other:_____

Cardiac/Circulatory: Have you had: (Circle any that apply) Heart attack? Angina? Aneurysm?

Thrombophlebitis (blood clot in legs)? Other:_____

Endocrine: Do you have: (Circle any that apply) Diabetes? Thyroid disease? Other:_____

Hepatic: Have you had: (Circle any that apply) Jaundice? Viral hepatitis? Gallbladder disease?

Other:_____

Gastrointestinal: Have you had: (Circle any that apply) Gastric reflux? Ulcers? Colitis?

Other:_____

Have you ever had colonoscopy? (Circle one) Yes No

Have you ever had black stools? (Circle one) Yes No

Kidney/Bladder: Have you had: (Circle any that apply) Nephritis (kidney failure)? Blood in urine?

Prostrate disease or cancer? Other:_____

Genital: Female: Have you had: (Circle any that apply) Breast cancer? Breast lumps?

Blood from nipple? Abnormal pap smear? Cervical or uterine cancer?

Fibroids? Other: _____

Last date of pelvic examination: _____/_____/_____

Last date of mammogram (over 40 years): _____/_____/_____

Was the mammogram **normal**: (Circle one) Yes No

Male: Have you had: (Circle any that apply) Testicular tenderness? Other:_____

Last date of Prostrate Specific Antigen (PSA) test: _____/_____/_____
(Black race: over 40 years, All Others: over 50 years)

Was the PSA test **normal**: (Circle one) Yes No

Neurological: Have you had: (Circle any that apply) Seizures? Trembling of hands? DT's?

Other:_____

Psychological: Have you had: (Circle any that apply) Depression? Thoughts of suicide?

Other:_____

NON-WORK ACTIVITIES: Describe your non-work activities before the injury and now (including recreation, sports, work around the house, driving, etc.).

Before injury:_____

_____

_____

_____

Currently:_____

_____

_____

_____

SOCIAL HISTORY:

Marital Status: (Circle one) Married Single Widowed Divorced

Children:_____ _____ Lives at home: (Circle one) Yes No
Name Age

Children:_____ _____ Lives at home: (Circle one) Yes No
Name Age

Children:_____ _____ Lives at home: (Circle one) Yes No
Name Age

Children:_____ _____ Lives at home: (Circle one) Yes No
Name Age

Children:_____ _____ Lives at home: (Circle one) Yes No
Name Age

Education: (Circle highest) Eighth Grade Tenth Grade High School Diploma

G.E.D. Some College 2 years college

4 years college Graduate degree Other:_____

Certifications: List any professional certifications

Certificate Name	Certificate Number	Date Awarded
		/ /
		/ /
		/ /

Habits:

Tobacco: Do you smoke? (Circle One) No Yes _____ Packs per day

Alcohol: Do you drink? (Circle One) No Yes _____ Amount

Did someone help you complete this questionnaire? (Circle One) Yes No

Name of person: (Please print) _____

Signature of person: _____

Date form completed: _____