GENERAL HISTORY FORM

Charles D. Potter, M.D.

INSTRUCTIONS:

Answer each of the questions on this form as completely as possible. Use the back side of the page if needed. This is a dictation template form and will make your report accurate. PLEASE DO NOT MAIL THIS FORM IN - bring it with you on the day of your appointment. If you have any questions, please call our office. PLEASE allow yourself an hour and a half for this appointment.

DATE: _____

PATIENT'S NAME: _____

AGE: _____ DOB: _____ SSN: _____

ADDRESS: _____

_____

PHONE #: _____ SEX: M F

MAJOR HAND: R L

HEIGHT: _____ WEIGHT: _____

DATES OF INJURY: _____

BODY PARTS AFFECTED BY INJURY: _____

_____

_____

_____

_____

EMPLOYMENT INFORMATION

EMPLOYER (at the time of injury): _____

TYPE OF COMPANY: _____

EMPLOYER'S ADDRESS: _____

_____

JOB TITLE: _____ HOW LONG HAD YOU WORKED THERE? _____

HOURS WORKED PER DAY:_____ DAYS WORKED PER WEEK: _____

HOW LONG HAD YOU DONE THIS TYPE OF WORK? _____

PLEASE DESCRIBE YOUR JOB DUTIES WHEN WORKING THIS JOB: _____

_____

_____

_____

_____

USING THE LEGEND GIVEN BELOW, WHAT PERCENTAGE OF AN AVERAGE WORK DAY (before the injury) WERE REQUIRED TO DO THE FOLLOWING ACTIVITIES: e.g. STANDING: F.

Legend	**C = Continuous**	**75 to 90% of the time**
	F = Frequent	**50 to 75% of the time**
	I = Intermittent	**25 to 50% of the time**
	O = Occasional	**1 to 25% of the time**

STANDING: _____ SQUATTING: _____ SITTING: _____

WALKING: _____ KNEELING: _____ DRIVING: _____

CLIMBING: _____ TWISTING: _____ BENDING: _____

PUSHING: _____ STOOPING: _____ DETAIL HAND WORK: _____

REACHING (above shoulder level): _____ PULLING: _____

HOW MUCH WEIGHT DID YOU LIFT? _____ HOW OFTEN (use legend)?_____

DID YOU WEAR PROTECTIVE EQUIPMENT? (if yes, please describe) _____

_____

_____

WERE YOU EXPOSED TO EXCESSIVE AMOUNTS OF DUST, GASES OR FUMES? (If YES, please describe)_____

_____

_____

WERE YOU REQUIRED TO WORK AROUND MOVING MACHINERY? (if yes, please describe): _____

_____

DATES MISSED FROM WORK DUE TO INJURY(S): _____

_____

_____

IF YOU ARE NO LONGER WORKING FOR THIS EMPLOYER, PLEASE COMPLETE THE FOLLOWING: DATE LAST WORKED _____

WERE YOU LAID OFF, FIRED OR DID YOU VOLUNTARILY LEAVE YOUR EMPLOYMENT?

_____

ARE YOU CURRENTLY ON: MEDICAL LEAVE _____ STATE DISABILITY _____

WORKERS' TEMPORARY DISABILITY _____ OTHER _____

WOULD YOU LIKE TO WORK FOR THE SAME EMPLOYER AGAIN? _____

DO YOU THINK YOU COULD DO THE SAME JOB? (if no, please explain)_____

_____

_____

SINCE THE INJURY, HAVE YOU WORKED OR ARE YOU CURRENTLY WORKING FOR A DIFFERENT EMPLOYER? _____ If yes, please list the employer(s) below:

EMPLOYER'S NAME: DATES OF EMPLOYMENT: JOB TITLE:

_____

_____

_____

_____

IF YOU ARE STILL WORKING FOR THE SAME EMPLOYER AS YOU WERE AT THE TIME OF INJURY, PLEASE COMPLETE THE FOLLOWING:

ARE YOU STILL DOING THE EXACT SAME JOB? YES _____ NO _____

IF NO, DESCRIBE THE DIFFERENCE _____

_____

_____

_____

_____

INJURY DESCRIPTION

DATE OR DATES OF SPECIFIC INJURIES: #1 _____

#2 _____ #3 _____ #4_____

PLEASE DESCRIBE HOW THE INJURY(S) HAPPENED. (If more than one injury, please number them)_____

WHAT SYMPTOMS DID YOU HAVE IMMEDIATELY FOLLOWING THE INJURY(S)?

MEDICAL TREATMENT

DESCRIBE THE MEDICAL ATTENTION YOU RECEIVED AFTER THE INJURY(S). PLEASE INCLUDE THE FOLLOWING: NAMES OF PHYSICIAN, MEDICATIONS & TREATMENT THEY PRESCRIBED, WHAT X-RAYS WERE TAKEN, PHYSICAL THERAPY, SURGERIES, HOSPITALIZATIONS, etc. **PLEASE DO NOT PUT "SEE MEDICAL RECORDS" - THIS INFORMATION IS TO BE FILLED OUT BY YOU**

WERE YOU EVER DENIED MEDICAL TREATMENT? YES_____ NO_____

If yes, explain why treatment was denied:_____

IF YOU ARE CURRENTLY WORKING, DESCRIBE ANY PROBLEMS THAT ARE INTERFERING WITH YOUR ABILITY TO WORK: _____

PRESENT COMPLAINTS:

PLEASE LIST ANY OUTSIDE ACTIVITIES OR OUTSIDE WORK YOU ARE DOING:

PLEASE LIST RECREACTIONAL ACTIVITIES YOU ARE UNABLE TO DO SINCE THE INJURY: _____

DESCRIBE YOUR PRESENT COMPLAINTS: type of pain, severity, duration, what causes the pain, what relieves the pain: _____

DESCRIBE ANY COMPLAINTS CAUSED BY THE INJURY THAT YOU HAD, BUT HAVE BEEN RESOLVED: _____

CURRENT TREATMENT

LIST THE DOCTORS THAT ARE CURRENTLY TREATING YOU AND TYPE OF TREATMENT YOU ARE RECEIVING: _____

CURRENT MEDICATION

INCLUDE ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATION YOU TAKE NOW

DRUG _____ DOSAGE _____ QUANTITY TAKEN _____

DRUG _____ DOSAGE _____ QUANTITY TAKEN _____

DRUG _____ DOSAGE _____ QUANTITY TAKEN _____

DRUG _____ DOSAGE _____ QUANTITY TAKEN _____

DRUG _____ DOSAGE _____ QUANTITY TAKEN _____

DRUG _____ DOSAGE _____ QUANTITY TAKEN _____

DRUG _____ DOSAGE _____ QUANTITY TAKEN _____

PAST WORK HISTORY

EMPLOYER JOB TITLE DATES EMPLOYED

_____

_____

_____

_____

PREVIOUS WORKERS' COMPENSATION CLAIM? YES_____ NO_____

PAST MEDICAL HISTORY

LIST PRIOR ACCIDENTS, INJURIES OR ILLNESSES INVOLVING THE SAME PART OF THE BODY (also list date of injury, and if you fully recovered from that injury) _____

_____

_____

_____

SINCE YOUR INJURY HAVE YOU HAD ANY ADDITIONAL INJURIES? (if yes, please describe) _____

_____

_____

LIST ALL PRIOR HOSPITALIZATIONS, SURGERIES OR INCIDENTS WHICH HAVE REQUIRED HOSPITAL CARE: _____

_____

_____

_____

LIST ALL ALLERGIES YOU HAVE AND THE TYPE OF REACTION YOU EXPERIENCE (medicine, food, or pollen): _____

_____

_____

_____

DID YOU HAVE ANY SERIOUS CHILDHOOD DISEASES? (such as scarlet fever, polio, strep throat, heart problems, heart murmur, kidney problems, whooping cough, etc.) _____

_____

_____

_____

ARE YOU CURRENTLY: MARRIED _____ SEPARATED _____ DIVORCED _____

WIDOWED _____ SINGLE _____

TOTAL NUMBER OF CHILDREN YOU HAVE _____

	FATHER	MOTHER	BROTHER	SISTER	GRANDPARENT
Diabetes	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____

PLACE OF BIRTH: _____

WHERE WERE YOU RAISED? _____

IF FOREIGN BORN, WHEN DID YOU MOVE TO THE UNITED STATES? _____

EDUCATIONAL LEVEL: HIGH SCHOOL _____ COLLEGE _____

MILITARY SERVICE: BRANCH _____ DATES _____

DO YOU DRINK COFFEE OR TEA? _____ HOW MUCH PER DAY? _____

DO YOU DRINK ALCOHOL? _____ HOW OFTEN _____ HOW MUCH _____

DO YOU USE TOBACCO? _____ IF YES, WHAT TYPE? _____

HOW MUCH PER DAY? _____ HOW LONG HAVE YOU USED IT? _____

DO YOU USE ILLICIT DRUGS? _____ HOW OFTEN? _____

WHAT TYPE? _____

FOR WOMEN ONLY: # OF PREGNANCIES _____ # OF LIVE BIRTHS _____

IS THERE ANY POSSIBILITY THAT YOU COULD BE PREGNANT? _____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE PROBLEMS WITH ANY OF THE FOLLOWING SYSTEMS (not caused by the injury)? IF YES, PLEASE DESCRIBE. IF NO, WRITE "NONE".

HEENT: (EARS, NOSE, THROAT) _____

_____

_____

RESPIRATORY: (LUNGS) _____

_____

_____

CARDIOVASCULAR: (HEART) _____

_____

_____

GASTROENTEROLOGY: (ESOPHAGUS, STOMACH, COLON) _____

_____

_____

GENITOURINARY: (KIDNEYS, BLADDER, GENITALS) _____

_____

_____

MUSCULOSKELETAL: (BONES, MUSCLES) _____

_____

_____

NEUROLOGIC: (NERVE, REFLEXES) _____

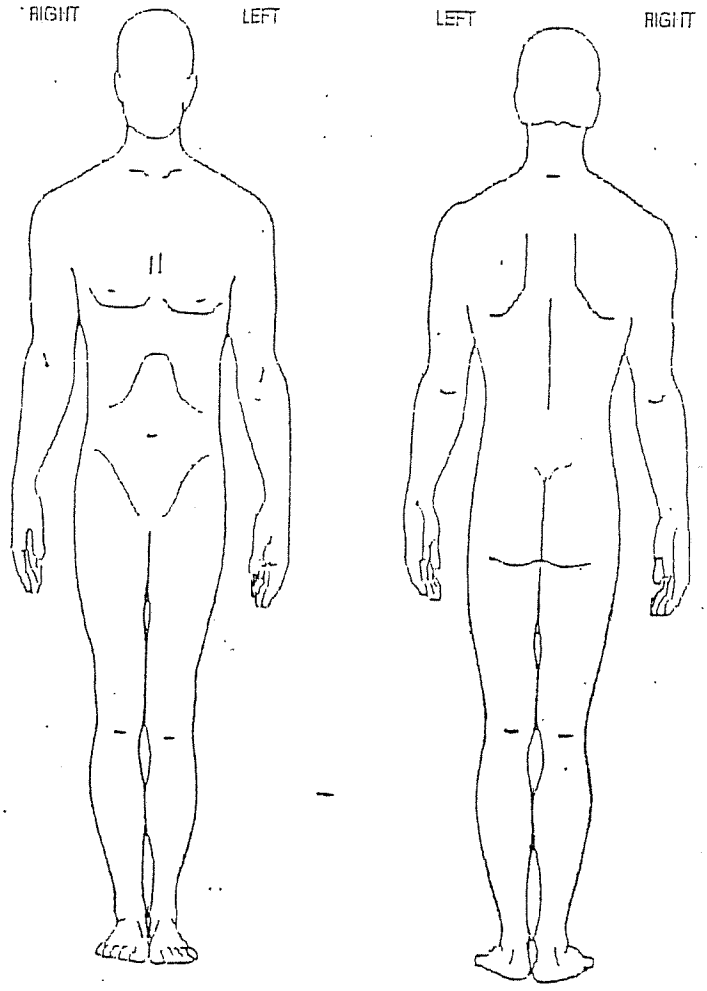
_____

_____

PAIN DRAWING

Using the key, describe your present ailment.

KEY:			
Major pain:	XXX	Tingling:	YYY
Secondary pains:	///	Burning:	ZZZ
Loss of Sensation:	OOO		



MAKE ANY COMMENTS YOU FEEL ARE IMPORTANT

g/wpmt/qpotter

Name:_____

Date:_____

Name:_____ Date:_____

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Rarely — All of the time

Total pain severity score (range from 0 to 20) = _____

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to **write or type?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

/
N _____ =

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**?

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

S
/
_____ =