JON PEMBROKE KELLY, M.D., F.A.A.O.S.

ORTHOPAEDIC SURGERY

PATIENT QUESTIONNAIRE

Date of Examination _____ Office Location _____

Name _____

DOB _____ Age_____ Soc. Sec. # _____

Address _____

City_____ State_____ Zip_____

Telephone Number ( ) _____

Height ___ ft. ___ in. o Right-handed o Left-handed

Weight _____ lbs.

Presently Working?: _____ Same Employer?_____

Currently Disabled? _____ Dates of TTD Status: _____

Date last worked: _____

Date of Injury _____Employer at Time of Injury _____

Body Part(s) Injured: _____

_____

_____

If there was no specific injury, when did you become aware of symptoms? _____

How do you believe this was work related?_____

Job Title at time of injury_____

Basic job duties/requirements: _____

Date of Hire: _____ Date you left: _____

Reason you left employment: _____

What Physical activities were required of your job, which have been affected by injury? (For example: Walking, lifting, bending at waist or neck, climbing ladders, working on inclines, grasping, fine manipulation, etc.) _____
_____
_____
_____

Present Employer & Job Title if different: _____

HISTORY OF INJURY

In your own words, please describe the injury and include: What were you doing? How did it occur? What part of your body was hurt? (Use other side if necessary)

_____
_____
_____
_____
_____

Did you report the injury? _____ If so, to whom? _____ When? _____

Describe your medical treatment:

Where were you seen first? _____
By Whom? _____
What treatment was provided? _____
Where else were you referred? _____
_____
_____
_____

Were you able to continue working? _____
If yes: modified _____ or regular_____

Were you later taken off work? _____ If so, when _____
by whom? _____
_____
_____

Were x-rays or other special studies done? o yes o no

SPECIAL STUDIES	Body Part	Date Performed	Location Performed	Result
EMG, NCV				
CT Scan				
MRI				
Bone Scan				
Myelogram				

Arthrogram				
Other				

Did you receive physical therapy? o yes o no If yes, for how long?
First day: _____
Last day: _____
How often? _____

Did this treatment help? o yes o no
Explain: _____
_____
_____

Did you have surgery? o yes o no

If yes, when? _____

By whom? _____

Are you still receiving treatment? o yes o no

If yes, what type? _____

Describe any further medical and/or chiropractic treatment you have received to this date, as a result of the injury(ies): _____
_____
_____
_____

Please list the names and dates from the first doctor you saw to the present:

Name	Specialty	City	Referred By	Exam Date

With the treatment provided to date, do you feel your condition is: o Fully recovered o Improved
o No change o Worse
Explain: _____
_____
_____
_____

Have you missed any time from work because of the injury? o yes o no
If yes, what was your first day of lost time? _____
If yes, when did you return to work? _____

Were you ever told to return to modified work? o yes o no

If yes, did you return to work? o yes o no When? _____
Is modified work available? o yes o no

When do you expect to return to your regular work? _____

CURRENT MEDICAL TREATMENT

Are you still seeing a doctor at this time? o yes o no

If yes, date last seen: _____

Next appointment _____ Doctor's name _____MD, DC, DO

How often? o Regularly o Weekly o Monthly o As Needed o Other

Are you taking any medications? o yes o no
If yes, name of medications: _____

How often do you take them? _____

Does the medication help you? _____

Are you receiving physical therapy? o yes o no

Is physical therapy helping? _____

Has your physician released you?_____

Has your physician performed a Permanent & Stationary Report? _____

PRESENT COMPLAINTS

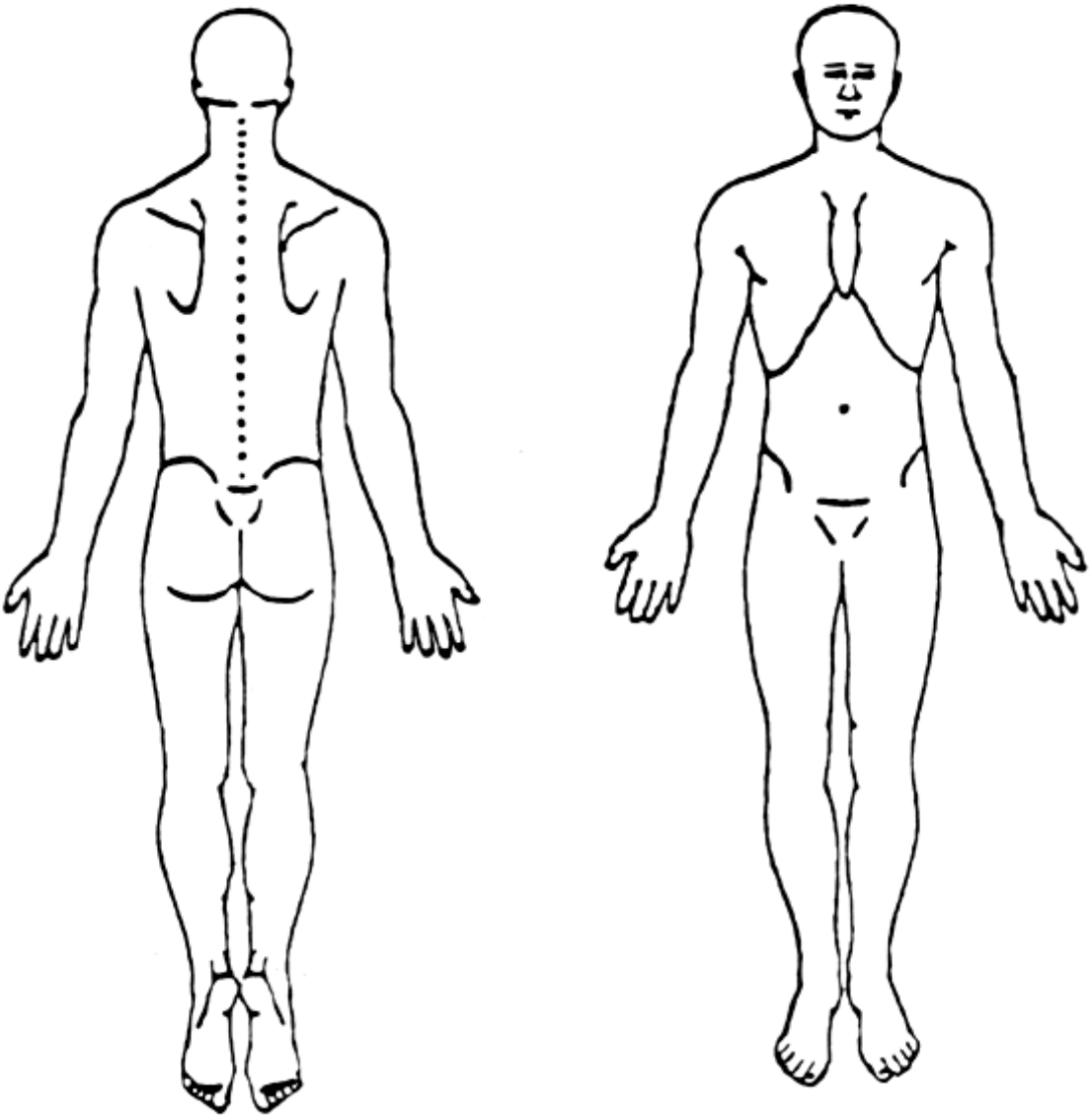
Are you still having pain? o yes o no If so, where? _____
_____

If so, describe it: (Where, how often, etc.) _____
_____
_____

How does it feel? (Sharp, dull, aching, stabbing, numb, tingling, etc.) _____
_____
_____
_____

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

Sharp pain	= XXXXX
Dull pain	= OOOOO
Numbness & Tingling	= /////////



Do you feel this discomfort:

- o Some of the time
- o Half of the time
- o Most of the time
- o Only during waking hours
- o Only with certain activities. Describe which activities: _____

_____

Does it change with coughing or sneezing? _____ If so, how? _____

_____

What makes it feel better? _____

_____

Does the pain awaken you from sleep? o yes o no
If yes, how often? _____

Were any of these problems present before the injury in question, or related to another injury, which occurred between then and now? _____

_____

_____

If you were having previous problems with the same body part involved in this claim, using the scales below, please circle the number that best estimates the amount of pain you were/are having.

Before the work injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? _____ If yes, where? _____

_____

How often does this occur? _____ What makes it better? _____

Is there any stiffness? o yes o no If yes, where? _____

Is there any numbness? o yes o no If yes, where? _____

Is there any tingling? o yes o no If yes, where? _____

Is there any weakness? o yes o no If yes, where? _____

Is there any swelling? o yes o no If yes, where? _____

Any grinding of the joints? o yes o no If yes, where? _____

Any locking of the joints? o yes o no If yes, where? _____

Any giving way of joints? ϖ yes o no If yes, where? _____

Are there any bowel or bladder problems (Incontinence)? o yes o no If yes, describe: _____
_____

How long can you *sit?* _____
stand? _____
walk? _____

Do you use any assistive device(s)? (cane, crutches, wheelchair, back support, splint, etc.) _____
_____

Please describe in your own words any other problems you are having at this time, which you related to the accident: _____
_____
_____

What can't you do now that you could before?_____
_____

Are you able to work at the present time? o yes o no
If you can, at your usual duties? _____

If not, what duties? _____
_____
If not, why not? _____
_____

How much can you lift now? _____Normally or in an altered fashion? _____
If altered, how so? _____

How much could you lift before? _____

Anything of additional importance, which you wish to report:
_____
_____
_____

WORK HISTORY

Name of employer at time of injury(ies): _____
How long were you employed there? _____ years _____ months
Job title: _____
Hours worked per day _____ per week _____ How long have you done this type of work? _____
_____

Describe your duties: _____

_____

Describe specific tools used: _____

How much are you required to lift, and how often? _____

Any work activities which are difficult for you to perform and why? _____

_____

Are you working now? o yes o no If yes, same job? _____ regular duty ____ light duty _____

If working for a different employer, name: _____

Brief job description: _____

_____

_____

Prior work experience (what type, physical demands, etc.): _____

_____

_____

_____

Are you currently receiving disability as a result of the work injury in question? o yes o no

If yes, from whom? o Workers' compensation insurance carrier

o State disability insurance fund

For how long? _____ years _____ months

Have you been recommended for, or have you participated in, a vocational rehabilitation program (retraining) as a result of this injury? o yes o no

If yes, please describe (date started, present status, occupation to be retrained in, etc.): _____

_____

_____

_____

PAST MEDICAL HISTORY

Prior to this industrial injury, have you ever had similar problems with, or injuries to, the body part or parts involved in this claim? o yes o no

If yes, please give details (IMPORTANT: Were you having problems at the time of the injury? Give dates, doctors, etc.) : _____

_____

_____

_____

_____

Have you had any work or non-work injuries since the injury involved in this claim? o yes o no

If yes, please explain: _____

_____

_____

Are the injured body parts still bothersome? o yes o no

Have you ever had any other work-related injuries? o yes o no If yes, please explain _____
_____
_____

Are the injured body parts still bothersome? o yes o no

Have you ever been involved in any motor vehicle accidents? o yes o no If yes, please describe:
_____
_____

Are the injured body parts still bothersome? o yes o no

Have you had any other serious accidents, sports injuries, or illnesses? o yes o no If yes, please describe: _____
_____

Did you ever receive a permanent disability settlement? o yes o no
If yes, when? _____

Do you have any medical problems or serious illnesses you are being treated for? _____
_____
_____

What medications are you taking, or have recently taken? _____
_____

Have you had any surgeries? If so, please describe: _____
_____
_____

Do you have any allergies to medication? o yes o no If yes, list: _____
_____

Other allergies? _____
_____

What diseases, if any, run in your family? _____
_____
_____

Check below if you have had any of the following diseases/illnesses as a child or as an adult:

		Diabetes		Kidney Disease		Epilepsy/Seizures	
Anemia		Pneumonia		Fracture		Hepatitis/Jaundice	
Hernia		Chicken Pox		Tuberculosis		High Blood Pressure	
Cancer		Skin Problems		Rheumatic Fever		Gallbladder	

Polio		Stool Disorders		Thyroid Disorder		Bleeding Disorder	
Ulcer		Mental Disorder		Arthritis		Asthma	
Sexually Transmitted Disease				Heart Disease		Other	

Do you have a personal family doctor or chiropractor? o yes o no
If yes, name: _____
Date last seen: _____ For what? _____

PATIENT PROFILE

Marital Status: o Married o Single o Separated o Divorced o Widowed

Number of children _____ Age range _____ Do they live with you? o yes o no

Years of education completed: _____ College Degree(s) _____
Special Training _____

Did you serve in the U.S. Military? o yes o no If yes, what branch? _____
Dates _____

Do you smoke cigarettes? o yes o no If yes, how much? _____
Do you drink alcoholic beverages? o yes o no If yes, how often? _____
Do you use any drugs (street, illegal)? o yes o no Comment: _____
_____
_____

Do you have any history of drug or alcohol habit/dependency/or abuse? o yes o no
Comment: _____
_____

Do you have any hobbies, special skills, or interests? o yes o no If yes, describe: _____
_____
_____

Do you participate in a fitness program, or any sports activities? o yes o no If yes, describe:
_____
_____

Has the injury in question hindered or stopped you from doing any of your usual activities? o yes o no
If yes, please explain your reasons why: _____
_____
_____
_____
_____

SYSTEMS REVIEW

Circle below if you have any of the following problems:

Heart/Circulation	**Bones/Joints**	**Stomach/Abdomen**	**Urogenital**
High Blood Pressure	Joint Pain	Nausea/Vomiting	Blood in Urine
Chest Pain	Joint Swelling	Peptic Ulcer Disease	Frequency/Urgency
Heart Attack	Stiffness	Pain	Getting up at Night
Swollen Feet		Sudden Weight Loss	Discharge
Poor Healing		Change in Bowel Habits	
		Hernia	
Neurological			
Numbness/Tingling		**Gynecological**	
Headaches		Pelvic Pain	
Coordination Problems	**Emotional/Psychological**		**Other**
Double Vision	Depression	Thoughts of Suicide	
Memory Loss	Anger	Loss of Appetite	
	Anxiety	Unusual stress	

PATIENT STATEMENT

The information given in this history questionnaire was provided by me or through an interpreter, and is true. I ACKNOWLEDGE THAT THE MEDICAL EVALUATION THAT I AM UNDERGOING TODAY IS STRICTLY FOR EVALUATION PURPOSES AND NOT INTENDED FOR TREATMENT.

Patient's Signature: _____ Interpreter: _____

Date: _____ Agency: _____