VIKRAM TALWAR, MD

INCORPORATED

Diplomat American Academy of Orthopedic Surgery

WORKERS COMPENSATION HEALTH QUESTIONNAIRE

Patient Name:____ Date of Birth:_________ Age:_________

Height: ________ Weight:_____________

Who referred you to our office? ______________________________

What is your job?____

Employer at time of injury:_____________________________________ How long did you work there?_______

How did you get hurt at work? __________

Please describe accident/injury:

Pain level today (1-10):________

Treatment Since Injury

	YES	NO	Number of Visits	Year
Physical Therapy				
Chiropractic				
Acupuncture				
Injections				

-Type(i.e epidural, facet, ablation):

Medications for injury: ***Please List***				
Brace				
Home Exercise Program				
Surgery				

-Type of Surgery:

Who has treated you so far (Provider names)?:

Did you miss work? ☐Yes ☐ No Is yes, when and how long?: ____________________________________

Are you working now? ☐ Yes ☐ No If yes, full duty or modified? _____________________________

Prior injuries to the same area? ☐ Yes ☐ No

If yes, when:__________ Did the symptoms resolve? ☐ Yes ☐ No

Symptoms now (1-10):______

Patient Name: ___________________________ Date of Birth:_____________

How often does the pain/numbness occur:☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent ☐ N/A

What is the status of your condition since the onset date:
☐ Unchanged ☐Improving ☐Fluctuating ☐Stable ☐Worse ☐ Resolved

Where type of pain/ numbness are you experiencing? Check all that apply ☐ No pain/numbness
☐ Ache ☐ Burning ☐ Deep ☐ Superficial ☐ Dull ☐ Localized ☐ Piercing ☐ Sharp ☐Shooting ☐ Throbbing ☐ Electric ☐ Tingling ☐ Numb ☐ Discomfort

What is the location of your pain/numbness? Check all that apply ☐ No pain/numbness

☐ Neck	☐ Upper back	☐ Mid back	☐ Lower back	☐ Gluteal area	☐ Flank
☐ Thighs	☐ Legs	☐ Shoulder	☐Arm	☐ Hand	☐ Fingers
☐ Other:_______	(circle one) RT / LT / Both	(circle one) RT / LT / Both	(circle one) RT / LT / Both	(circle one) RT / LT / Both	(circle one) RT / LT / Both

Below "X" the areas you feel pain

FRONT **BACK**

Circle which best describes your pain:

0 No Hurt | 2 Hurts Little Bit | 4 Hurts Little More | 6 Hurts Even More | 8 Hurts Whole Lot | 10 Hurts Worst

What aggravates your condition? Check all that apply ☐ Nothing aggravates my condition
☐ Daily activity ☐ Ascending stairs ☐ Descending stairs ☐Coughing ☐ Driving
☐ Flexion ☐ Extension ☐ Lifting weight ☐ Rotating/twisting ☐ Bending ☐ Standing
☐ Sitting ☐ Walking ☐ Exercise ☐ Lying down/sleep ☐ Other:________________

What relieves your condition? Check all that apply ☐ Nothing relieves my condition
☐ Ice ☐ Heat ☐ Elevation ☐Mobility ☐ Rest ☐ Stretching ☐ Exercise ☐ Brace
☐ Massage ☐ Physical therapy (how many visits completed):_____ ☐ Acupuncture ☐ Chiropractic
☐ Injection ☐ OTC meds (which med):______________
☐ Pain medication (which med):____
Pain level after taking your medication: No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including OTC/vitamins/herbals/supplements)

☐ **No medications to list**
☐ See attached medications list
Are you taking blood thinners? ☐ Yes ☐ No

Medication	Dosage & Frequency	Purpose & Administered route i.e. oral/IV/topical	Physician

Patient Name: ___________________________ Date of Birth:_____________

DRUG & OTHER ALLERGIES (list):

☐ NO KNOWN DRUG ALLERGIES

Have you had a fall in the last 12 months? ☐Yes ☐ No More than 2 times? ☐Yes ☐ No

SOCIAL HISTORY

Do you smoke tobacco products? ☐Yes ☐ No If yes, have you ever tried to quit? ☐Yes ☐ No

Type:_______________________ Packs per day:_____________________ Years used:______________

Do you drink alcohol? ☐Yes☐ No If yes, how many drinks per week?_____________

Do you presently use any recreational drugs? ☐Yes☐ No If so, please list: ______________________

Have you traveled or lived outside the US or Canada? ☐Yes☐ No If yes, when/where:____________

PAST MEDICAL AND FAMILY HISTORY

Illness/Condition	**Self**	**Relative**	**Describe**
Anesthesia complications	☐Yes ☐No	☐Yes ☐ No	
Bleeding prob/blood clots	☐Yes ☐No	☐Yes ☐ No	
Cancer	☐Yes ☐ No	☐Yes ☐ No	
Diabetes	☐Yes ☐ No	☐Yes ☐ No	
Heart disease	☐Yes ☐ No	☐Yes ☐ No	
Hepatitis/HIV	☐Yes ☐ No	☐Yes ☐ No	
High Blood Pressure	☐Yes ☐ No	☐Yes ☐ No	
Liver disease	☐Yes ☐ No	☐Yes ☐ No	
Psychiatric illness	☐Yes ☐ No	☐Yes ☐ No	
Stroke/TIA	☐Yes ☐ No	☐Yes ☐ No	
Tuberculosis	☐Yes ☐ No	☐Yes ☐ No	
Other:	☐Yes ☐ No	☐Yes ☐ No	

Do you have a chronic illness ☐Yes ☐ No If yes, what is it:

DIAGNOSTIC HISTORY ☐ None

Study	Within 6 months	Within 1 year	Body Part
X-rays	☐Yes ☐ No	☐Yes ☐ No	
MRI/CT	☐Yes ☐ No	☐Yes ☐ No	
EMG/nerve conduction studies	☐Yes ☐ No	☐Yes ☐ No	
Myelogram	☐Yes ☐ No	☐Yes ☐ No	
Bone scan/DEXAscan	☐Yes ☐ No	☐Yes ☐ No	
Other:	☐Yes ☐ No	☐Yes ☐ No	

Patient Name: ___________________________ Date of Birth:_____________

PRIOR SURGERY				☐ None
Name of Operation	Reason	Date	Facility	Physician

REVIEW OF SYSTEMS

CHECK IF YOU HAVE ANY OF THE FOLLOWING

Constitutional
- ☐ Fever/chills/night sweats
- ☐ Weakness/fatigue
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other:____________

Cardiovascular
- ☐ Stroke/blood clots
- ☐ Chest pain
- ☐ Abnormal heart rhythm
- ☐ High blood pressure
- ☐ Heart problem:_____________________________
- ☐ Other:____________________________________

Integumentary
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesions
- ☐ Other: ____________

Ear, Nose, Throat & Eyes
- ☐ Eye/vision disorders
- ☐ Frequent sore throat
- ☐ Vertigo/dizziness
- ☐ Voice hoarseness
- ☐ Difficulty swallowing
- ☐ Other: ___________

Gastrointestinal (GI)
- ☐ Constipation/diarrhea
- ☐ Liver/gallbladder issues
- ☐ Nausea/vomiting
- ☐ Ulcers
- ☐ Heartburn/reflux
- ☐ Black or bloody stool
- ☐ Other: ____________

Neurological
- ☐ Diff. walking/balance
- ☐ Dizziness
- ☐ Seizures
- ☐ Headache
- ☐ Weakness/numbness
- ☐ Neurologic problem
- ☐ Other: ________________

Respiratory
- ☐ Lung issues:_________
- ☐ Recent cold/flu
- ☐ Wheezing/asthma
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Abnormal chest x-ray
- ☐ Other: ____________

Genitourinary
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Kidney disease
- ☐ Bladder leakage
- ☐ Other: ___________

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Mood disorder
- ☐ Other:____________

Allergic/Immunologic
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Hives/Eczema
- ☐ Autoimmune disorder
- ☐ Other:____________

Musculoskeletal
- ☐ Arthritis/osteoporosis
- ☐ Broken bones
- ☐ Joint pain/swelling
- ☐ Carpal tunnel
- ☐ Other:____________

Endocrine
- ☐ Diabetes – I or II
- ☐ Parathyroid/Paget's
- ☐ Heat/cold intolerance
- ☐ Thyroid disorder
- ☐ Other:____________

Hematology/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Enlarged glands
- ☐ Anemia
- ☐ Blood transfusions
- ☐ Other:______________________________________

Females Only
- ☐ Pregnant
- ☐ Last menstrual period: ______________________

Other:

☐ ALL NEGATIVE

Office use:

Pulse:_____________ BP:_____________ BMI:____________

General Appearance: ☐ Well nourished ☐ Not well nourished ☐ Stand Normally ☐ Doesn't stand normally

Oriented x 3: ☐ Awake ☐ Responsive ☐ Oriented of person/place/time

Mood and Affect: ☐ Normal ☐ Not Normal

__________________________________ __________________________________

Patient Signature (Date) Provider Signature (Date)