Medix Occupational Health Services
886 Tanglefoot Ln.
Bettendorf, IA 52722
515.964.9003 Phone
515.964.9032 Fax
www.gotomedix.com

John D. Kuhnlein, DO, MPH, FACPM, FACOEM
Robin L. Sassman, MD, MPH, MBA, CIME, FACOEM
Mark C. Taylor, MD, MPH, CIME, FACOEM
Dennis B. Phillips, DO, MPH, FAAFP, FACOEM
Occupational and Environmental Medicine

Independent Medical Evaluation History Questionnaire

Instructions

Complete this history questionnaire, to the best of your ability, prior to your appointment. If you do not understand a question, simply leave it blank. We will review this with you at your appointment.

Please return your questionnaire to your attorney to be e-mailed, faxed (515.964.9032), or mailed to our office prior to your appointment, and *bring a copy of your completed questionnaire to your appointment*.

Note that your independent medical evaluation may last **2-3 hours** depending on your situation. Please plan accordingly.

© John Kuhnlein, DO, MPH 2014

INDEPENDENT MEDICAL EVALUATION QUESTIONNAIRE

Your Full Name ____Your Age ______________

Are you ☐ Right Handed ☐ Left Handed

Job Analysis

THESE QUESTIONS APPLY TO THE JOB YOU WERE DOING AT THE TIME OF THE INJURY IN QUESTION

Employer Information:

What company were you working for at the time of the incident in question?

What does this company make/do?

When did you start working there?____________What shift did you work?______________________

Did you work ☐ part-time or ☐ full-time? Are you still working there? ☐ Yes ☐ No

If no, the last date you worked was ___________.

Job Title/Tasks:

What was your job title at the time of this injury? ____

Was this job ☐ seasonal or ☐ year round?

Concurrent Employment:

Did you have another job for another company at the time of the injury? ☐ Yes ☐ No

If yes, please list:

Employer(s)	Job title	Hours per week worked

Material Handling:

What was the heaviest thing you would lift? _______

How much did it weigh? _______

What was the range of weight in pounds you worked with most of the time? ____________________

Please estimate how much time you spent working:

Below your waist ☐

Between your waist and shoulder height ☐

Above your shoulder ☐

(Total should equal 100%)

© John Kuhnlein, DO, MPH 2014

Nonmaterial Handling: How much of the workday did you spend doing these activities?

Nonmaterial Handling	**Never**	**Rare** *Less than 5% of the day*	**Occasional** *5-33% of the day*	**Frequent** *34-66% of the day*	**Constant** *More than 2/3 of the day*
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Climbing Ladders	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐
Gripping or Grasping	☐	☐	☐	☐	☐
Using Vibratory Tools	☐	☐	☐	☐	☐

Environmental Factors: How much of your workday was spent working

Indoors ______________________% Outdoors ____________________%

Hot/Warm environment? _________% Cold/Cool environment? _______%

Did you work outside in all weather? ☐ Yes ☐ No

Exposures: What chemicals could you have been exposed to in the workplace?

Tool Use: What types of tools did you work with? Please include both manual and power tools.

What heavy equipment did you work with? (Such as forklifts or trucks)

What types of personal protective equipment did you work with on a regular basis?

☐ Gloves ☐ Hearing Protection ☐ Hard Hats ☐ Fall Protection

☐ Respirator ☐ Steel toed footwear ☐ Safety Glasses ☐ Other ________

Job Satisfaction: Did you like your job? ☐ Yes ☐ No

Did you have a good relationship your coworkers? ☐ Yes ☐ No

Did you work well with your supervisor? ☐ Yes ☐ No

© John Kuhnlein, DO, MPH 2014

History

Please briefly outline in your own words how the injury/illness occurred:

Current Care:

What physicians or chiropractors, or other health care provider are you seeing

ONLY FOR THIS CONDITION NOW?

Current Medical Treatment for this injury now:

Medication ______________________________

Physical Therapy ☐ Yes ☐ No

Exercise? ☐ Yes ☐ No

Other ______________________________

Current Symptoms:

Please outline your symptoms below. Try to include whether your pain is constant, the severity, where it is located, etc. We will go through this also during the evaluation.

© John Kuhnlein, DO, MPH 2014

BACK PAIN PATIENTS ONLY!!

What effect does coughing or sneezing have on your back pain?

☐ Decrease ☐ No Effect ☐ Increase

What effect does bearing down to have a bowel movement have on your back pain?

☐ Decrease ☐ No Effect ☐ Increase

Can you control your bladder functions? ☐ Yes ☐ No

Can you control your bowel movements? ☐ Yes ☐ No

Current Work Activities:

Are you working now? ☐ Yes ☐ No For the same employer? ☐ Yes ☐ No

In the same job? ☐ Yes ☐ No

For a different employer? ☐ Yes ☐ No

If you work for a different employer, what company?

When did you start working here?

What job are you doing? ____________________

Current Work Restrictions:

Do you currently have work restrictions assigned by a physician? ☐ Yes ☐ No

What are they?

Are they **temporary** or **permanent**?

Are you able to work within these restrictions? ☐ Yes ☐ No

If you are having problems, please list them.

Aggravating and Relieving factors <u>AT WORK</u>:

What kind of problems do you have at work?

☐ Lifting	☐ Pushing	☐ Pulling	☐ Carrying	☐ Walking
☐ Sitting	☐ Standing	☐ Stooping	☐ Crawling	☐ Kneeling
☐ Working between floor/ waist	☐ Working between waist/ shoulders	☐ Working over shoulders	☐ Working Outdoors	☐ Working in hot/ cold weather
☐ Using legs	☐ Working on ladders	☐ Going up/ down stairs	☐ Gripping/ grasping objects	☐ Using hand tools/power tools

© John Kuhnlein, DO, MPH 2014

What do you do to make your symptoms better **AT WORK**?

Aggravating and relieving factors AT HOME:

Please check the following activities that cause you problems, due to your injury, at home.

Please check all that apply.

- ☐ Travel Standing
- ☐ Personal Hygiene
- ☐ Writing
- ☐ Typing
- ☐ Climbing Stairs
- ☐ Sitting
- ☐ Reclining
- ☐ Walking
- ☐ Feeling w/Fingers
- ☐ Lifting
- ☐ Pushing
- ☐ Pulling
- ☐
- ☐ Gripping
- ☐ Grasping
- ☐ Intimacy

What do you do to make your symptoms better **AT HOME**?

Changes in Symptom Pattern:

When you compare your symptoms now, to:

One year ago:	☐ Better?	☐ About the same?	☐ Worse?
Six months ago:	☐ Better?	☐ About the same?	☐ Worse?
Three months ago:	☐ Better?	☐ About the same?	☐ Worse?

Past Occupational History:

List your past employers **most recent FIRST.**

Employer	Job	No. of years	Why did you leave?

© John Kuhnlein, DO, MPH 2014

Past Medical History:
Please list any **operations/surgeries** you have had in the past.

Please list any **OTHER MEDICAL (NON-SURGICAL) problems** you have or have had in the past:

Prior Worker's Compensation Injuries:

Have you ever had another worker's compensation case in the past? ☐ Yes ☐ No
If yes, please list below:

Year	Injury	Employer	Impairment Assigned

Prior Injuries/Illnesses in the Same Area:

Have you ever had another injury **to the same area before** this injury? ☐ Yes ☐ No
If yes, when and what happened?

Previous Impairment Ratings:

Have you had a **previous impairment rating** for the **same** body part? ☐ Yes ☐ No
If yes, what was the rating given, and when?

Intervening Injuries in the Same Area:

Have you had any **new injuries to the same area** since the injury in question? ☐ Yes ☐ No
If yes, when and what happened?

© John Kuhnlein, DO, MPH 2014

Current Medications:

Prescription medications: **Non prescription medications:**

Allergies:

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, list medication(s):

Social History:

Tobacco Use:

Do you smoke? ☐ Yes ☐ No How many packs per day?

Number of years? ________________ If you quit smoking, what year did you quit?

Other form of tobacco? ☐ Chewing Tobacco ☐ Cigars ☐ Pipe

Alcohol Use:

Do you drink alcoholic beverages? ☐ Yes ☐ No

How many alcoholic beverages do you drink per week?

What type of alcoholic beverage do you drink?

Are you using alcohol for pain management? ☐ Yes ☐ No

Substance Use:

Are you using any illegal substances? ☐ Yes ☐ No

Family Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How many children do you have? ____

Education:

What was the last grade you completed in school?

☐ Grade School ☐ High School ☐ Some College ☐ College Graduate ☐ Graduate Degree

Do you have a GED? ☐ Yes ☐ No

© John Kuhnlein, DO, MPH 2014

Military Service:

Have you served in the military? ☐ Yes ☐ No Branch ____________________

Were you injured while in the military? ☐ Yes ☐ No

If yes, explain:

Do you have a service connected disability? ☐ Yes ☐ No

If yes, explain:

Sleep Patterns:

On average, how many hours per night do you sleep? ____________________

Do you awaken with a sore throat? ☐ Yes ☐ No Headache? ☐ Yes ☐ No

Do you awaken rested in the morning? ☐ Yes ☐ No

If you have problems getting a good night's sleep, why? ____________________

Have you ever had or been advised to have a sleep study? ☐ Yes ☐ No

Leisure Time Activities:

What did you do in your free time before this injury/illness? Please circle the activities you can no longer perform.

Caffeine Intake:

Caffeine intake per day: cups of coffee ______ soft drinks ______ energy drinks ______

At what time during the day do you stop drinking caffeinated beverages?

Disability Status:

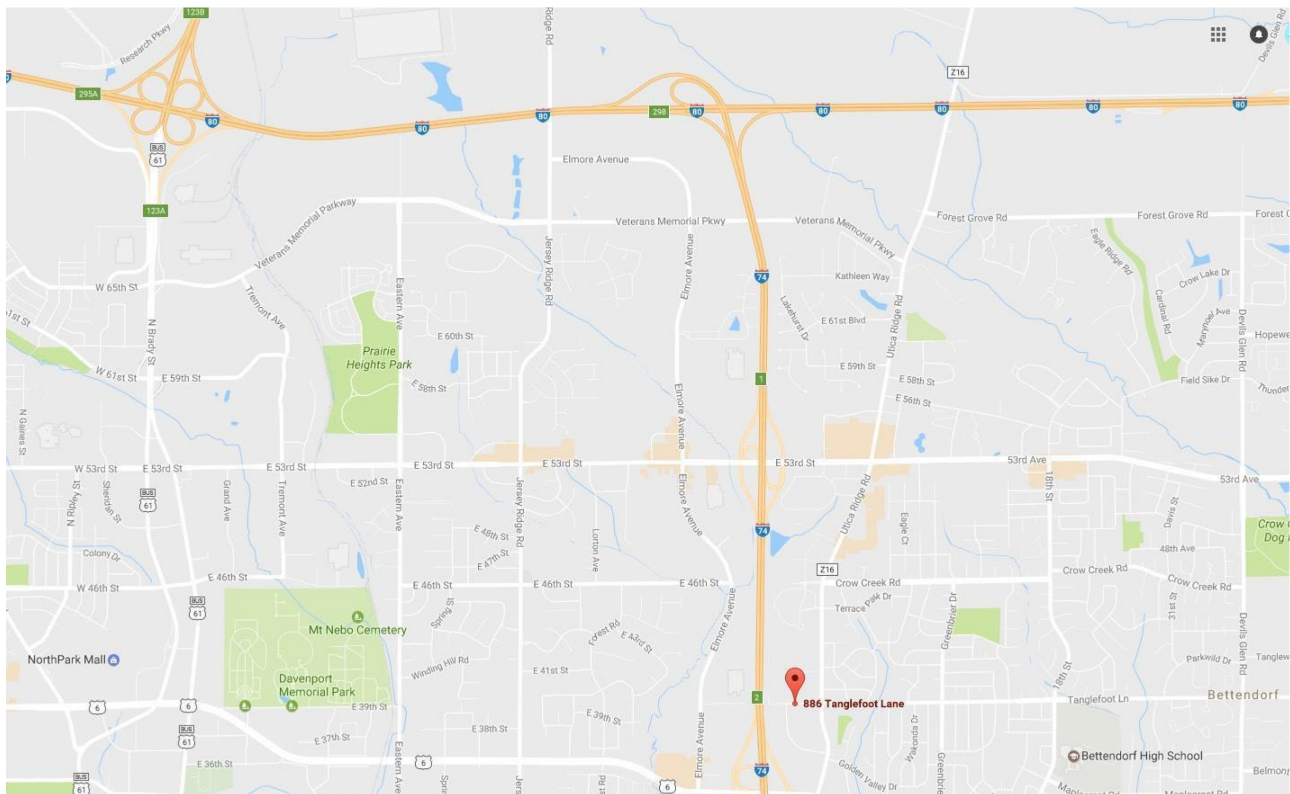
Are you on, or applying for Social Security Disability or other Disability Benefits? ☐ Yes ☐ No

If yes, when were they granted? ____________________

© John Kuhnlein, DO, MPH 2014

Medix Occupational Health Services
886 Tanglefoot Ln
Bettenfort, IA 52722
515.964.9003 Phone
515.964.9032 Fax
www.gotomedix.com

Get Google Maps Directions



© John Kuhnlein, DO, MPH 2014