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## 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.

# 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%)**

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

<b>Nonmaterial Handling</b>	<b>Never</b>	<b>Rare</b> <i>Less than 5% of the day</i>	<b>Occasional</b> <i>5-33% of the day</i>	<b>Frequent</b> <i>34-66% of the day</i>	<b>Constant</b> <i>More than 2/3 of the day</i>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gripping or Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using Vibratory Tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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

# 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.

**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 AT WORK:**

What kind of problems do you have at work?

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> Lifting                         | <input type="checkbox"/> Pushing                             | <input type="checkbox"/> Pulling                   | <input type="checkbox"/> Carrying                         | <input type="checkbox"/> Walking                            |
| <input type="checkbox"/> Sitting                         | <input type="checkbox"/> Standing                            | <input type="checkbox"/> Stooping                  | <input type="checkbox"/> Crawling                         | <input type="checkbox"/> Kneeling                           |
| <input type="checkbox"/> Working between floor/<br>waist | <input type="checkbox"/> Working between waist/<br>shoulders | <input type="checkbox"/> Working over<br>shoulders | <input type="checkbox"/> Working<br>Outdoors              | <input type="checkbox"/> Working in hot/<br>cold weather    |
| <input type="checkbox"/> Using legs                      | <input type="checkbox"/> Working on<br>ladders               | <input type="checkbox"/> Going up/<br>down stairs  | <input type="checkbox"/> Gripping/<br>grasping<br>objects | <input type="checkbox"/> Using hand<br>tools/power<br>tools |

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.

- |  |   |                                    |                                   |
|--|---|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Travel            | <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Writing   | <input type="checkbox"/> Typing   |
| <input type="checkbox"/> Standing          | <input type="checkbox"/> Sitting          | <input type="checkbox"/> Reclining | <input type="checkbox"/> Walking  |
| <input type="checkbox"/> Climbing Stairs   | <input type="checkbox"/> Lifting          | <input type="checkbox"/> Pushing   | <input type="checkbox"/> Pulling  |
| <input type="checkbox"/> Feeling w/Fingers | <input type="checkbox"/> Gripping         | <input type="checkbox"/> Grasping  | <input type="checkbox"/> Intimacy |

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

**Changes in Symptom Pattern:**

When you compare your symptoms now, to:

- |                          |                                  |  |                                 |
|--------------------------|----------------------------------|--|---------------------------------|
| <b>One year ago:</b>     | <input type="checkbox"/> Better? | <input type="checkbox"/> About the same? | <input type="checkbox"/> Worse? |
| <b>Six months ago:</b>   | <input type="checkbox"/> Better? | <input type="checkbox"/> About the same? | <input type="checkbox"/> Worse? |
| <b>Three months ago:</b> | <input type="checkbox"/> Better? | <input type="checkbox"/> About the same? | <input type="checkbox"/> Worse? |

**Past Occupational History:**

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

Employer	Job	No. of years	Why did you leave?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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?

**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



**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? \_\_\_\_\_

# Medix

Medicine at Work

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