



Medix Occupational Health Services
1824 SW White Birch Circle
Ankeny, Iowa 50023
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.

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?

Nonmaterial Handling	Never	Rare <i>Less than 5% of the day</i>	Occasional <i>5-33% of the day</i>	Frequent <i>34-66% of the day</i>	Constant <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					
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting					
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling					
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Ladders					
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gripping or Grasping					
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/waist | <input type="checkbox"/> Working between waist/shoulders | <input type="checkbox"/> Working over shoulders | <input type="checkbox"/> Working Outdoors | <input type="checkbox"/> Working in hot/cold weather |
| <input type="checkbox"/> Using legs | <input type="checkbox"/> Working on ladders | <input type="checkbox"/> Going up/down stairs | <input type="checkbox"/> Gripping/grasping objects | <input type="checkbox"/> Using hand tools/power 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 Standing | <input type="checkbox"/> Personal Hygiene | <input type="checkbox"/> Writing | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Sitting | <input type="checkbox"/> Reclining | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Feeling w/Fingers | <input type="checkbox"/> Lifting | <input type="checkbox"/> Pushing | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> | <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:

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



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