Medix
Medicine at Work

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Personal Injury
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.

PERSONAL INJURY
INDEPENDENT MEDICAL EVALUATION QUESTIONNAIRE

Your Full Name:_____ Your Age:_____

Are you: ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

History of the Injury

Outline in your own words what happened. Please be as specific as possible.

Current Clinical Status:

I am not seeing any health care providers now ☐

What physicians or chiropractors, or other health care providers are you seeing **for this condition**, at this time?

How often are you seeing your health care provider?

What medical treatments are you doing for **this problem** now? Please included any medications, physical therapy, stretching exercises or anything you do to help.

Medications:

Physical Therapy:

Other:

Current Symptoms:

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

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	☐ Personal Hygiene	☐ Writing	☐ Typing
☐ Standing	☐ Sitting	☐ Reclining	☐ Walking
☐ Going up/down stairs	☐ Lifting	☐ Pushing/pulling	☐ Carrying
☐ Feeling with fingers	☐ Squatting	☐ Grasping/gripping	☐ Intimacy

Past Medical History:
Please list any **other medical** problems; any other illnesses or injuries at any time, not just this one?
If you need more space, please continue on the back of this sheet.

Please list **any surgeries** you have had in the past.
Include all surgeries, not just for the condition for which I am seeing you.
If you need more space, please continue on the back of this sheet.

Have you ever had any **symptoms or injuries in the same location *before*** this injury? ☐ Yes ☐ No
If so, please outline below. Include the year, and what happened.

Have you ever had any **symptoms or injuries in the same location *since*** the injury? ☐ Yes ☐ No

Current Medications:
Are you taking any prescription, nonprescription medications?
Are you taking any vitamins, or herbal medications?

Please list, including doses and how often you take your medication.

Prescription Medications:	Non Prescription Medications:	Vitamins/Herbal Medications

Allergies:
Do you have any allergies to medications? ☐ Yes ☐ No
If yes, list medication(s):

Do you have any environmental allergies (Hay fever)? ☐ Yes ☐ No

Social History:

Tobacco Use:
Do you smoke? ☐ Yes ☐ No How many packs per day? _____
If you quit smoking, what year did you quit? _____

Family Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Sleep Patterns:
On average, how many hours per night do you sleep? _____
Do you awaken rested in the morning? ☐ Yes ☐ No
If you have problems getting a good night's sleep, why? _____

Leisure Time Activities:
What did you do in your free time before this injury/illness?

Please circle the activities you can no longer perform.

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