

**Fullerton Orthopaedic Surgery Medical Group, Inc.
Worker's Comp History Form**

Please answer these questions regarding your workers compensation injury. A medical assistant will review the form with you after it is completed.

Date: _____

Name: _____

Home Address: _____ City _____ Zip _____

Work Address: _____ City _____ Zip _____

Telephone: (home) _____ (work) _____

Date of Birth: _____ Age; _____ Soc. Sec # _____

Marital Status _____ # of Children _____ Ages: _____

History of Present Injury

Have you had a injury at work? _____

What part(s) of the body were injured? _____

What was the date (s) of the injury? _____

Who was your employer at the time? _____

What was your occupation at that time? _____

How long had you been working there at that time? _____

How did you injury / accident / condition happen? _____

Did you finish what you were doing? ____ Did you report it? _____

When? _____ To whom? _____ Did you fill out forms? _____

Are you working now? _____

History of Initial Treatment

When did you first see a doctor? _____

Whom did you see? _____ Specialty _____

Address _____ City _____

Who referred you to this doctor? _____

What tests were done? (Circle appropriate below)

X-ray _____ CT Scan _____ EMG _____ Myelogram _____

Arthrogram _____ MRI _____ other _____

Date (s) performed _____ Results _____

What were you told was wrong? _____

What treatment was suggested? (Check any appropriate)

Rest _____ Medication _____ Physiotherapy _____ How often? _____

Injection _____ Surgery _____ Hospitalization? _____ Dates _____

Other _____

List below any other doctors that you have seen for this injury, starting with the one you saw after the doctor listed above, and ending with the most recent you have seen.

1). Name and Specialty _____

Address _____

Month / Year seen _____

Who referred you to this doctor? _____

Did you receive any of the following? (Check below)

Rest _____ Medication _____ Physiotherapy _____ How often _____

Injection _____ Surgery _____ Hospitalization? _____ Dates _____

Did you have any test? (Check any appropriate below)

X-ray, _____ CT Scan _____ EMG _____ Myelogram _____

Athrogram _____ MRI _____ Other _____

Date (s) performed: _____

2). Name and Specialty _____

Address _____

Month / Year seen? _____

Who referred you to this doctor? _____

Did you receive any of the following? (Check any appropriate)

Rest _____ Medication _____ Physiotherapy _____ How often? _____

Injection _____ Surgery _____ Hospitalization? _____ Dates _____

Other _____

Did you have any tests? (Check any appropriate)

X-Ray _____ CT Scan _____ EMG _____ Myelogram _____ Arthrogram _____

MRI _____ Other _____

When did you return to work? _____ Same employer? _____

Same Job? _____ Restrictions? _____

Date last worked? _____ Dates out of work because of this injury? _____

_____ Any other incidents that made you worse? _____

Explain _____

Present Complaints

Do you have any pain? _____ Where is it? _____

What does it feel like? (Sharp, dull, aching, stabbing, etc)

Did any of these symptoms exist prior to your injury / illness?

Explain: _____

Does your present pain travel? _____ Where? _____

How often does it happen? _____

What makes it worse? _____

What makes it better? _____

Is there any stiffness? _____ Where? _____

Is there numbness? _____ Where? _____

Is there any tingling? _____ Where? _____

Any Weakness? _____ Where? _____

Any Swelling? _____ Where? _____

Grinding? _____ Where? _____

Locking? _____ Where? _____

Give away? _____ Where? _____

Do you have difficulty with bowel, bladder, or sexual function? _____

Deformity / scar? _____ Where? _____

Are you Right or Left - Handed? _____

Past Medical History

Previous injuries, non-work-related:

1). Date _____ What body part was involved? _____

Treatment _____ How Long? _____ Resolved? _____

With whom did you treat? _____

Did you miss any time from work due to this injury? _____ How much? _____

2). Date _____ What body part was involved? _____

Treatment? _____ How Long? _____ Resolved? _____

With whom did you treat? _____

Did you miss any time from work due to this injury? _____ How much? _____

Previous injuries work-related

1). What part of the body was involved? _____

Employer _____ Date _____ Treatment _____

How long? _____ Resolved? _____

With whom did you treat? _____

Did you miss work due to injury? _____ How long? _____

2). What body part was involved? _____

Employer _____ Date _____ Treatment _____

How long? _____ Resolved? _____

With whom did you treat? _____

Did you miss work due to this injury? _____ How long? _____

Previous surgery; give dates: _____

List all medications you are taking. _____

Are you allergic to any kind of food or medication? _____

List them: _____

What allergic reaction occurs? _____

Dates of military service _____ Branch _____

Medical discharge? _____

Family History:

Have you or any member of your immediate family been treated for the following?
(Self, Mother, Father, Sister, or Brother)

Tuberculosis _____ Who? _____

Cancer _____ Who? _____

Arthritis _____ Who? _____

Kidney _____ Who? _____

Asthma _____ Who? _____

Heart _____ Who? _____

Epilepsy _____ Who? _____

Stomach _____ Who? _____

Dizziness _____ Who? _____

Nerves _____ Who? _____

Muscular _____ Who? _____

Hypertension _____ Who? _____

Bowel or Bladder _____ Who? _____

Excessive Bleeding _____ Who? _____

Rheumatic Fever _____ Who? _____

GYN (female) _____ Who? _____

Diabetes _____ Who? _____

Liver Problems _____ Who? _____

Social History

Do you smoke? _____ How Much? _____ How Long? _____

Do you drink alcohol? _____ How Much? _____ How Long? _____

Hobbies: _____

Occupational History

Present Employer _____ Occupation _____

How long have you been working there? _____

In Chronological order:

Previous Employer _____ Occupation _____

From _____ To _____

Previous Employer _____ Occupation _____

From _____ To _____

Previous Employer _____ Occupation _____

From _____ To _____

Previous Employer _____ Occupation _____

From _____ To _____

Patient's Signature _____ Date _____

Interpreter _____ (If Applicable)

Authorizing Signature _____

(If patient is a minor)

Medical Historian: _____