OSNC Orthopaedic Specialists of North County

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General Workers' Comp / Industrial Medicine Questionnaire

Name: _____ Chart#_____Date: _____

☐ Right-handed ☐ Left-handed

Height_____ Weight_____

1. History of Injury

Date of injury: _____

Date last worked: _____

Date you notified employer of your injury: ☐ No ☐ Yes

Describe how you were injured: _____

_____

_____

_____

2. Employment Data

Name of employer at time of injury: _____

Address: _____

Type of business: _____

How long have you been working for this employer (or) date you were hired: _____

Job title: _____

Briefly describe your work duties/activities: _____

_____

Place of injury or address: _____ ☐ Same as above ☐ Other

Have you had treatment or an examination for this injury? ☐ No ☐ Yes

If yes, please list, in order, names of physicians or hospitals and treatments below:

Name	Treatment
_____	_____
_____	_____
_____	_____

General Workers' Comp Industrial Medicine Questionnaire (cont.)

List your present complaints / areas of pain caused by this injury: _____

_____

_____

Have you ever had any problems in this area of injury or similar injury in the past? ☐ No ☐ Yes

If yes, briefly describe:

_____

_____

3. Work History

Did you lose any time from your job because of this injury? ☐ No ☐ Yes

At any time were you on modified/limited duty? ☐ No ☐ Yes

If you answer yes to either question above, list the dates you were unable to work or did modified work.

_____ to _____ ☐ Unable to work ☐ Modified

_____ to _____ ☐ Unable to work ☐ Modified

_____ to _____ ☐ Unable to work ☐ Modified

Are you back to work? ☐ No ☐ Yes Date returned: _____

Same employer: ☐ No ☐ Yes Date returned: _____

If no, why not?_____

_____

_____-_____

List any previous work injuries: _____

_____

Are you being retrained? _____

Past medical history: _____

_____

Allergies to medication? _____

Current medications:_____