

MICHAEL P. MULDOON, M.D.
IME HISTORY FORM

NAME: _____ DATE: _____

- 1) Have you ever seen any of our doctors before? _____ If so, when? _____
- 2) Please write down in your own words what current medical complaints you have which you feel were caused by the accident _____

- 3) What type of accident did you have? (please circle one)
Automobile Motorcycle Other _____
- 4) What was the date of your accident? _____

AUTOMOBILE ACCIDENT

- a) Were you driving? () were you a passenger? ()
 - b) Where were you seated in the vehicle? (right front seat, left rear?) _____
 - c) Was your seat belt fastened? Yes () No ()
 - d) Did your seat have a headrest? Yes () No ()
 - e) Was your vehicle stopped? Yes () No ()
 - f) Was the car struck head-on? () broadside? () rear-ended? ()
 - g) Were you aware a collision was going to occur? Yes () No ()
 - h) Was the force of impact slight? () moderate? () severe? ()
 - i) Did you strike anything in the car? Yes () No ()
- If so, what did you strike? _____

(Please continue to number 5.)

MOTORCYCLE AND OTHER ACCIDENT

Please describe your accident: _____

(Please continue to number 5.)

- 5) Were you unconscious? Yes () No ()
 - a) Did you have any immediate symptoms? Yes () No ()
 - b) If you had immediate symptoms, please describe them: _____

 - c) If not, when were you aware you were injured? _____
 - d) What were your injuries? _____

- 6) Were you taken to a hospital emergency room by ambulance? (), police vehicle? (), or a private vehicle? ()
 - a) What hospital were you taken to? _____
- 7) If you were not taken to a hospital, when did you first seek medical care? _____
- 8) What doctor did you see? _____

- 9) What did the doctor tell you was wrong with you? _____

- 10) What treatment did you have, how often, and for how long? (therapy, chiropractic, acupuncture, etc.) _____

- 11) Are you getting better? () remaining the same? () getting worse? ()
- 12) Have you ever had any symptoms similar to those which you now have before the accident? () if so, please describe: _____

- 13) Have you ever had a similar accident? Yes () No ()
- 14) Have you ever had any other serious accidents requiring medical care? _____
If so, what were they? _____

- 15) Have you ever had any serious illnesses requiring medical care? _____
If so, what were they? _____

- 16) Have you ever had surgical operations? _____ if so, please list them with the years: _____

- 17) What medicine(s) are you taking? _____
a) Are you allergic to any medicine? Yes () No () If yes, please list: _____

- 18) Have you ever had any nervous or mental illnesses, or psychiatric care? _____

- 19) Have you ever received a medical discharge from the Armed Forces? _____
If so, for what reason: _____
- 20) Were you employed at the time of this accident? Yes () No ()
a) If yes, what was your occupation? _____
b) If any time was lost from work, please give dates: _____

- c) Were you working full-time? () part-time? ()
d) Have you returned to your regular job? Yes () No ()
e) If yes, when did you return? _____
f) If not, please explain: _____

- g) If not, do you think you will be able to do the same job as before?
Yes () No ()
h) When do you think you will be able to return to work? _____
- 21) What activities (vacuuming, lawn mowing, etc.), sports and hobbies can you no longer do since this accident? _____

FAMILY HISTORY (If significant to the present injury)

SOCIAL HISTORY

Education completed through: _____

Hobbies: _____

Since the injury, what hobbies have you not been able to do? _____

Do you smoke? _____ How much per day? _____ How long? _____

Do you drink? _____ How much per day? _____ How long? _____

If you have any current medical complaints in areas not listed below, please describe them on the last page. Thank You.

CURRENT MEDICAL COMPLAINTS

BACK PAIN

I have pain in my: low back midback upper back

My pain began: gradually suddenly

I have pain: sometimes all of the time

My pain goes into my: right leg left leg both legs

I have tingling and/or numbness in my: right leg left leg both legs

My pain is worse when I:

cough or sneeze yes no

sit yes no

bend yes no

walk yes no

lift yes no

push yes no

pull yes no

stand yes no

My pain is worse with sexual activity:

yes no

My pain awakens me in the middle of the night:

yes no

Changes in weather affect my pain:

yes no

BACK PAIN SCALE. PLEASE CIRCLE ON THIS SCALE THE LEVEL OF YOUR PAIN.
(zero indicates no pain, 10 indicates the most severe pain)

0 1 2 3 4 5 6 7 8 9 10

NECK PAIN

My pain began: gradually suddenly
I have pain: sometimes all of the time
My pain goes into my: right arm left arm both arms
I have tingling and/or
numbness in my: right arm left arm both arms

My pain is worse when I:

cough or sneeze yes no
bend forward yes no
lift yes no
push yes no
pull yes no
turn my head yes no

My pain awakens me in the middle of the night:
 yes no

Changes in weather affect my pain:

yes no
I have neck stiffness: yes no
I have headaches: yes no
If I get headaches they occur:
 sometimes all of the time

NECK PAIN SCALE. PLEASE CIRCLE ON THIS SCALE THE LEVEL OF YOUR PAIN.
(zero indicates no pain, 10 indicates the most severe pain)

0 1 2 3 4 5 6 7 8 9 10

KNEE PAIN

How long have you had trouble with your knee(s)?

_____ weeks, _____ months, _____ years

How long have you had your present pain?

_____ weeks, _____ months, _____ years

My knee pain began:

I have pain: gradually suddenly
 sometimes all of the time

My pain is worse when I:

squat	<input type="checkbox"/> yes	<input type="checkbox"/> no
kneel	<input type="checkbox"/> yes	<input type="checkbox"/> no
climb up stairs	<input type="checkbox"/> yes	<input type="checkbox"/> no
climb down stairs	<input type="checkbox"/> yes	<input type="checkbox"/> no
run	<input type="checkbox"/> yes	<input type="checkbox"/> no
sit	<input type="checkbox"/> yes	<input type="checkbox"/> no
walk	<input type="checkbox"/> yes	<input type="checkbox"/> no
jump	<input type="checkbox"/> yes	<input type="checkbox"/> no

My knee(s):

swell	<input type="checkbox"/> yes	<input type="checkbox"/> no
catch	<input type="checkbox"/> yes	<input type="checkbox"/> no
lock	<input type="checkbox"/> yes	<input type="checkbox"/> no
give way	<input type="checkbox"/> yes	<input type="checkbox"/> no
feel unstable	<input type="checkbox"/> yes	<input type="checkbox"/> no
pop, click, grate	<input type="checkbox"/> yes	<input type="checkbox"/> no

KNEE PAIN SCALE. PLEASE CIRCLE ON THIS SCALE THE LEVEL OF YOUR PAIN.
(zero indicates no pain, 10 indicates the most severe pain)

0 1 2 3 4 5 6 7 8 9 10

Do you have any other areas of the body with pain? Please describe: _____

USE THE SPACE BELOW TO ADD ANY INFORMATION NOT COVERED IN THIS FORM.
THANK YOU.

Please mark on the diagram where your pain is located.

