

William E. Bowman, M.D.

DATE: _____

Type of Report: AOE/COE 2ND Opinion Consult QME AME

Interpreter _____ Company _____

Job Description

Name: _____ Age: _____ Right/Left Handed

Employer at the time of injury: _____

Job Title: _____

Number of hours per day? _____ How many days per week? _____

Basic work duties at the time of injury: _____

Estimate the amount of weight you lifted during the day: _____

Did you work somewhere else at the same time you worked for this employer? _____

If yes, what were your duties? _____

List places of employment for the last 10 years:

1) Employer _____ Position _____ How long? _____

2) Employer _____ Position _____ How long? _____

3) Employer _____ Position _____ How long? _____

History of Injury

Specify date of injury: _____

If there is no specific date of injury, when did you first begin to have problems? _____

Tell in your own words what happened: _____

Did you continue to work? _____

When did you report this injury? _____ To whom? _____

When did you **first** receive treatment? _____

Did you have? _____ X-Rays? _____ Medication _____ Injections _____ Therapy

List all physicians seen:

1) Dr. _____ Date seen: _____
Treatment given: _____ X-Rays _____ Medication _____ MRI _____ Injections
_____ Splints _____ Physical Therapy _____ Times per week for _____ weeks
Did any treatment help? _____ If yes, what helped? _____
What were you told was the problem? _____

2) Dr. _____ Date seen: _____
Treatment given: _____ X-Rays _____ Medication _____ MRI _____ Injections
_____ Splints _____ Physical Therapy _____ Times per week for _____ weeks
Did any treatment help? _____ If yes, what helped? _____
What were you told was the problem? _____

Did you return to work? _____ If yes, when? _____

Are you working for the employer? _____ If no, who is your present employer? _____

What are your new duties? _____

If you did not return to work when you were released, why? _____

List all dates you did not work.

From _____ to _____

List all dates you performed light duty.

From _____ to _____

When did you return to regular duty? _____

Since this injury, have you had any other injuries? _____

If yes, what body parts were injured? _____ Date of injury: _____

Was this work related? _____ If yes, describe all treatment and where you received the treatment: _____

Past Medical History

Have you had any previous work related injuries? _____ If yes, describe in detail: _____

Have you had any injuries to the body parts involved in this claim in the past? _____
If yes, were these work related? _____

When did this occur? _____ If work related, did you receive a disability rating? _____
If yes, what was the rating? _____

Medical History

Circle any and all conditions listed below that you have received treatment for in the past.

Diabetes	Heart Murmur	High Blood Pressure	Asthma
Ulcers	Lung Problems	Kidney Problems	Arthritis
Tumors/Cancer			

List previous surgeries and dates: _____

List present medications: _____

List any allergies to medications: _____

**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:	<input type="checkbox"/> low back	<input type="checkbox"/> mid back	<input type="checkbox"/> upper back
My pain began:	<input type="checkbox"/> gradually	<input type="checkbox"/> suddenly	
I have pain:	<input type="checkbox"/> sometimes	<input type="checkbox"/> all of the time	
My pain goes into my:	<input type="checkbox"/> right leg	<input type="checkbox"/> left leg	<input type="checkbox"/> both legs
I have tingling and/or Numbness in my:	<input type="checkbox"/> right leg	<input type="checkbox"/> left leg	<input type="checkbox"/> both legs

My pain is worse when I:

Cough or sneeze	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sit	<input type="checkbox"/> yes	<input type="checkbox"/> no
Bend	<input type="checkbox"/> yes	<input type="checkbox"/> no
Walk	<input type="checkbox"/> yes	<input type="checkbox"/> no
Lift	<input type="checkbox"/> yes	<input type="checkbox"/> no
Push	<input type="checkbox"/> yes	<input type="checkbox"/> no
Pull	<input type="checkbox"/> yes	<input type="checkbox"/> no
Stand	<input type="checkbox"/> yes	<input type="checkbox"/> 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:

() gradually () suddenly

I have pain:

() sometimes () all of the time

My pain is worse when I:

- | | | |
|-------------------|---------|--------|
| Squat | () yes | () no |
| Kneel | () yes | () no |
| Climb up stairs | () yes | () no |
| Climb down stairs | () yes | () no |
| Run | () yes | () no |
| Sit | () yes | () no |
| Walk | () yes | () no |
| Jump | () yes | () no |

My knee(s):

- | | | |
|-------------------|---------|--------|
| Swell | () yes | () no |
| Catch | () yes | () no |
| Lock | () yes | () no |
| Give away | () yes | () no |
| Feel unstable | () yes | () no |
| Pop, click, grate | () yes | () 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: _____

PATIENT HEALTH QUESTIONNAIRE

PATIENT'S NAME: _____ AGE: _____ DATE: _____

What are you seeing the doctor for? _____
Date of injury? _____ Did this injury happen while at work? { } yes { } no

Are you being treated for any other medical problems? { } yes { } no If yes – What?

Height? _____ Weight? _____

Are you { } right-handed, { } left-handed or { } ambidextrous

List any allergies to any medications:

List your current medications:

yes no
{ } { } Do you smoke? – If yes, how much?
{ } { } Do you drink alcohol? – If yes, how much?
{ } { } If female – Is there any possibility that you are pregnant at this time?

What kind of operations have you had? (When?) { } None
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Do you have or have you had?
yes no yes no yes no
{ } { } Angina, Chest pain { } { } Mitral valve prolapse { } { } Thyroid disease
{ } { } Heart "attack" { } { } Severe headaches { } { } Diabetes
{ } { } Irregular heart beat { } { } Asthma { } { } Epilepsy, Stroke
{ } { } High blood pressure { } { } Hepatitis { } { } Kidney disease
{ } { } Heart disease { } { } Bleeding disorder { } { } Drug addiction
{ } { } Cancer { } { } Lung disease { } { } Other _____

Does any member of your family have or have they ever had?
{ } Arthritis { } Heart disease { } Diabetes { } Blood disorders
{ } High blood pressure { } Muscular disease { } Cancer