

**William E. Bowman, M.D.**

DATE: \_\_\_\_\_

Type of Report:    AOE/COE    2<sup>ND</sup> 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?  

<b>yes</b>	<b>no</b>		<b>yes</b>	<b>no</b>	<b>yes</b>	<b>no</b>		
{ }	{ }	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