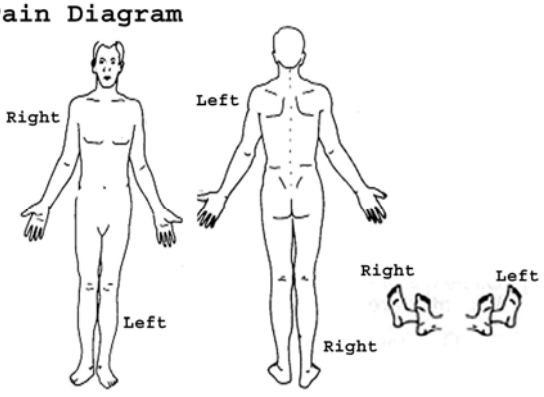
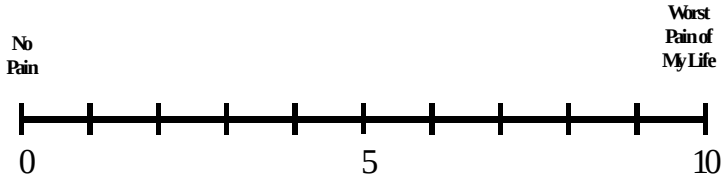
UC Davis Medical Center, Department of Orthopaedic Surgery Adult Reconstructive Surgery Unit	Use Patient Plate		
	Today's Date		
Workman's Compensation Questionnaire All information in this questionnaire will be included in your medical record and will be held strictly confidential.			
Name: (Last, First, M.I.)	☐ **M** ☐ **F**	**Date of Birth**	**Age**
Name: (Last, First, M.I.)	☐ **M** ☐ **F**	**DOB:**	

History of Present Illness	
What part of your body is driving you to seek medical attention? ☐HIP ☐KNEE ☐ OTHER	
Which side?	If you have an injury to the affected part, when did it occur?
How did the injury or accident happen?	

Pain Diagram





What makes your pain better? (rest, ice, heat, massage, medications)	
What makes your pain worse? (activity,	

walking, running, bending, squatting)	
What is the quality of your pain (sharp, dull ache, burning, other)	
How many hours a day do you have this pain?	
Do you have pain at rest?	☐Yes ☐No
Does the pain radiate to anywhere else? If yes, where?	
Do you have any of the following?	
swelling ☐Yes ☐No	popping or clicking ☐Yes ☐No
numbness ☐Yes ☐No	giving way ☐Yes ☐No
What limitations of your daily routine do you have due to this injury?	
Have you injured this area prior to this injury? If so, explain.	

Occupational Information

What is your job title?	
Did your injury occur at work?	☐Yes ☐No
Was it due to a single injury or due to a gradual problem?	☐Single injury ☐Gradual
Who was your employer at the time of the injury?	
Please describe how the injury occurred.	
Have you reinjured yourself since that time?	☐Yes ☐No
How would you described the function of the injured body part BEFORE the injury?	☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor(Constant Pain)
Name of the First doctor that you saw after the injury?	Date?
How did you get there? ☐Driven ☐Ambulance ☐Other	
What initial tests did you have? ☐Xrays ☐CT ☐MRI ☐EMG ☐Bone Scan	
What treatment was initially performed?	
Were you taken off work? ☐Yes ☐No	
Were you given modified duty? ☐Yes ☐No	
Were you hospitalized? ☐Yes ☐No	
Did you have physical therapy? ☐Yes ☐No	

List other medical specialists that you have seen since the initial visit after your work related injury. Start with the first one after the initial evaluation and end with the most recent visit.

Name	Date seen	Tests (EMG, CT, MRI, Bone scan)	Treatment	Hospitalized? If yes, dates?	Surgery? If yes, what procedure?

Work Status Since Time of Injury?
On what approximate date did you return to work?
How many days of lost work did you have?
What date did you work last?
Do you have a new employer since your injury? ☐Yes ☐No
What are your usual duties?
What are current work duties can you not perform as a result of your injury?
How long have you been working with your present employer?
Do you have to lift?
If so how much?
Do you have to kneel, bend, or squat? ☐Yes ☐No
If so how often?
Please list your previous employers in chronological order (most recent first)

Employer	Occupations	Dates

Do you use any walking aids		☐Yes ☐No
If so, what do you use?	☐Cane	☐Walker ☐Crutches ☐Wheelchair
What percent of the time do you use walking aids?		%
Do you use any braces?		☐Yes ☐No
Do you use any orthotics in your shoes? If yes, please explain:		☐Yes ☐No Explain
How far can you walk?		☐Miles ☐Yards ☐Blocks
What treatments have you had for your current condition?		
Cortisone injections? If yes, when and how often?		☐Yes ☐No Explain
Viscosupplementation? (Synvisc, Hyalgan) If yes, when and how often?		☐Yes ☐No Explain
Do you take any antiinflammatory medications?		☐Yes ☐No
Do you take Chondroitin Sulfate and Glucosamine?		☐Yes ☐No
Do you have difficulty with stairs?		☐Yes ☐No
Do you have more difficulty going up or down stairs?		☐ Up ☐Down
Do you put both feet on each step?		☐Yes ☐No
Do you use a rail when going up and down steps?		☐Yes ☐No
Can you put on your shoes and socks?		☐Yes ☐No
Can you cut your toenails yourself?		☐Yes ☐No

Please list any known medical conditions or problems.	**Year of onset**

Please list surgeries that you have undergone.	**Year performed**

Injuries, Car Accidents, or Broken Bones:				
Year	Incident	Treatment	Status	Work Related?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Please list any over the counter or prescribed medications.		
Drug Name	Strength or Dose	Taken when and how often?
Medication Allergies: ☐ No Known Allergies OR		1. 2. 3.

FAMILY HISTORY: Please list any illnesses of family members or cause of death if known.

	Age	Mark X if Alive and Well	Mark X if deceased	Describe family member illness or cause of death if known
Mother				
Father				
Sisters				
Brothers				
Children				

Review of Systems: Check if you have had, or currently have any of the following symptoms and the date of onset

	Symptom	Date of Onset
☐	Fevers	
☐	Chills	
☐	Night Sweats	
☐	Rashes/Frequent Itching	
☐	Sores that don't heal	
☐	Hearing Loss	
☐	Nasal Problems	
☐	Difficulty Swallowing	
☐	Thyroid Problems	
☐	Weight Loss	
☐	Weight Gain	
☐	Excessive sweating	
☐	Tremor	
☐	Chest Pain	
☐	Shortness of Breath	
☐	Cough	
☐	Enlarged Heart	
☐	Irregular Heart Beat	
☐	Heart Murmur	
☐	Wheezing	
☐	Vein Problems	
☐	Others:	

	Symptom	Date of Onset
☐	Phlebitis	
☐	AIDS	
☐	Hepatitis B	
☐	Hepatitis C	
☐	Previous Deep Vein	
☐	Transient Ischemic	
☐	Seizures	
☐	Calf Pain on Exertion	
☐	Easy Bruisability	
☐	Swollen Nodes	
☐	Paralysis	
☐	Weakness	
☐	Numbness	
☐	Tingling in Arms or	
☐	Painful Urination	
☐	Frequent Urination	
☐	Bloody Urine	
☐	Bleeding Ulcers	
☐	Hiatal Hernia	
☐	Frequent Indigestion	
☐	Colitis	

Social and Activity History: This information may impact your health insurance. If you have any concerns about this please leave the information blank and discuss it verbally with your physician to ensure confidentiality.

Smoking (Tobacco)		**How many per day?**	**How many years?**
Cigarettes	☐Yes ☐No		
Cigars	☐Yes ☐No		
Pipe	☐Yes ☐No		
Alcohol	☐Yes ☐No		
Illicit Drugs	Are you currently using or have you used any illicit drugs such as methamphetamine or cocaine? ☐Yes ☐No		
	Have you ever used intravenously injected drugs such as heroin? ☐Yes ☐No		
Highest Grade of School Completed	☐Elementary ☐HighSchool ☐College ☐Post-Graduate		

Current Occupation	
Marital Status	☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Hobbies/Activities/Sports	How many hours a week do you perform these activities?

Physical Examination (To be filled out by MD)

General			Standing Alignment ☐Varus ☐ Valgus Deg						
App			Gait ☐ Trend ☐Antalgic Side						
Hip						Knee			
TTP	☐Yes ☐No Location					Effusion		Standing Alignment	
ROM (Extension)						TTP			
Flexion	Extension		ABD			Medial		Lateral	
ADD	ER		IR			Stability			
ROM (90 Flexion)						Varus		Valgus	
Flexion	Extension		ABD			Lachman		Post Drawer	
ADD	ER		IR			Patellofemoral Joint			
Anterior Apprehension			Posterior Apprehension			Crepitance		Apprehension	
LLD	☐Eql	☐R>L	☐L>R	cm?		Flexion		Extension	
Vascular DP		PT							
Sensory			DTR	KJR R	L		AJR R	L	
Motor Q	JS	TA	GS	EHL	FHL				