QUALIFIED MEDICAL EXAMINATION HISTORY FORM — David S. Chang, M.D.

Date:_____

Please answer the questions below. Use separate page if needed, do NOT write on back of page. The information is very important and should be filled out completely before coming to your appointment.

Name: _____ Address: _____ City _____ State _____

Phone: _____ SSN: _____

Sex: M F Age: _____ Birth Date: _____ Ht: _____ Wt: _____ Major Hand: Right Left

Date(s) of injury: (1)_____ (2)_____ (3)_____ (4)_____

Body-part(s) injured: (1)_____ (2)_____ (3)_____ (4)_____

How long with current employer? _____ Last day worked? _____ How long did you do this type of work? _____

Dates missed from work due to injury(s):_____

Periods of modified duty _____

Work Preclusions: _____

_____

Are you still working for the same employer as you were at the time of the injury? Yes ____ No ____

If No, what is last date of actual work at employer where you had your most recent work injury: _____

If Yes, are you doing the exact same job? Yes ____ No ____ If No, please describe the differences:

_____

_____

Are you currently on medical leave? Yes ____ No ____ Do you receive State Disability payments? Yes ____ No ____

Workers' Compensation temporary disability payments? Yes ____ No ____ Other? _____

Do you feel physically able to return to your regular duties? Yes ____ No ____ If No, what job duties did you perform that you can no longer do? _____

Do you wish to return to lighter duty for the same employer? Yes ____ No ____

Have you been contacted by a Vocational Rehabilitation Agency? Yes ____ No ____ Is Rehab underway? Yes ____ No ____

JOB DUTIES AT THE TIME OF INJURY	
Employer Name:	Job Title at time of Injury:
Hours worked per day:	Hours worked per week:
Description of Job Responsibilities: (Describe all activities you did on the job - what you did at work.)	

ACTIVITY LEVELS: Please indicate the activities you performed at work. Base this information on your job description and what duties you were required to do at the time of your injury.
***PLEASE DESCRIBE YOUR HEAVIEST/HARDEST DAY AT WORK.**

Activity	**Frequency performed - Total Per Work Day**			
	Never 0 hours	Occasional up to 3 hours	Frequent 3-6 hours	Constant 6-8+ hours
Lifting				
Carrying				
Overhead use of arms				
Pushing				
Pulling				
Grasping				
Fine Manipulation - hands				
Repetitive hand use				
Reaching - arms				
Crawling				
Jumping				
Bending - neck				
Bending - waist				
Sitting				
Standing				
Kneeling				
Squatting				
Walking - uneven terrain				
Walking on flat surface				
Running				
Stooping				
Twisting - neck				
Twisting - waist				
Driving				
Climbing				
Downward gazing				
Upward gazing				
Please indicate the daily lifting and carrying requirements of the job: Indicate the height the object is lifted from the floor, table or overhead location and the distance the object is carried.				

Lifting							
Weight (pounds)	Never 0 hours	Up to 3 hours	Frequently 3-6 hours	Constantly 6-8+ hours	Floor	Table	Overhead
Carrying							
Weight (pounds)	Never 0 hours	Up to 3 hours	Frequently 3-6 hours	Constantly 6-8+ hours	Distance Carried		

Describe the heaviest item(s) you were required to carry and the distance carried:

How much could you lift (in pounds) before this injury? _____

How much could you lift (in pounds) right after the injury? _____

How much can you lift (in pounds) now? _____

Have you been seen by a prior QME for this injury? Yes No If Yes, who: _____

Have you been made Permanent and Stationary? Yes No

If Yes, by which doctor? _____

Since the injury, have you worked/are you currently working for a different employer? Yes No

If Yes, please list:

Employer's name	Dates of Employment	Job Title	Reason Job Ended

At the time of the injury, were you working for more than one employer? Yes ____ No ____

If yes, please list employer(s) and type of work performed.

_____

_____

DESCRIPTION OF INJURY FOR THE DATE(S) OF INJURY(S) LISTED ABOVE:

Please describe <u>in detail</u> how the injury(s) occurred.

If there was more than one injury, please number them. Use a separate page if needed.

What symptoms did you have <u>immediately after</u> the injury(s)?

MEDICAL TREATMENT:

Describe the medical attention you received after the injury(s). Please include the following: names of all physicians, the dates you saw them, medications & treatments they prescribed, what x-rays were taken, physical therapy, surgeries, hospitalizations etc.
(Dates of treatment can be listed as a "from - to" period, i.e. 3/4/09 – 4/6/10).

****Please do not put "see medical records"- <u>this information is to be filled out by you</u>!**

Doctor and/or Facility Name	Dates Seen	Treatment provided

PRESENT COMPLAINTS: PLEASE BASE THIS ON WHEN YOUR PAIN IS AT ITS WORST.
Describe: type of pain, severity, duration, what causes the pain, and what relieves the pain **per body part** claimed or injured.

_____

_____

_____

_____

_____

_____

_____

_____

_____

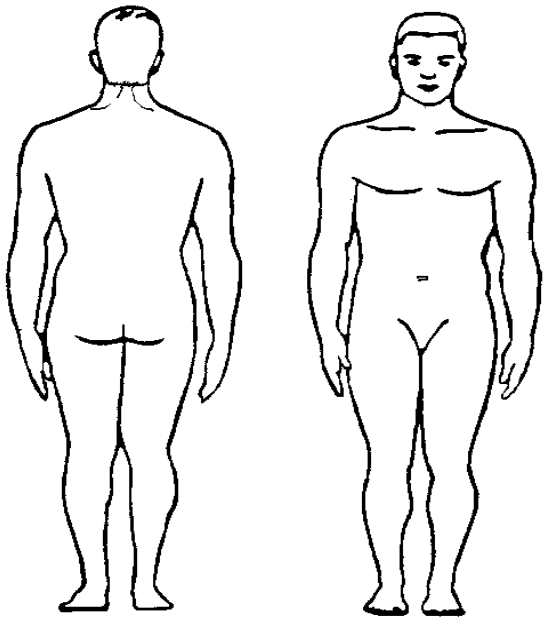
On the body chart below, mark the painful areas with the appropriate symbols:

Numbness = = = =	**Burning x x x x**	**Stabbing / / / /**	**Aching o o o o**	**Pins & Needles - - - -**

Also, next to each painful area, write the <u>two</u> words, one word from each column below, which best describes the intensity and frequency of your pain:

Intensity	**Frequency**
Minimal	Occasional
Slight	Intermittent
Moderate	Constant
Severe	

PLEASE DESCRIBE HOW YOUR PAIN FEELS AT IT'S WORST



Describe complaints that were caused by the injury(s), but have now gone away.

_____

_____

_____

_____

Do you feel your symptoms have improved, stayed the same, or worsened since the injury (please explain per body part claimed):

Body Part	Symptoms are better, worse, or the same

Before this injury(s), did you have any work limitations or restrictions in the use of the injured body part or parts?

_____

_____

_____

Activities of Daily Living Questionnaire

For each question below, please check "Yes" or "No." If you answer "Yes," please explain in the space below the question.

Do you experience any difficulties or limitations with:

Feeding yourself? □ No □ Yes

Bathing yourself? □ No □ Yes

Grooming yourself? □ No □ Yes

Dressing yourself? □ No □ Yes

Bowel or bladder function? □ No □ Yes

Sexual function? □ No □ Yes

Sitting? □ No □ Yes

Transferring positions? □ No □ Yes

Standing? □ No □ Yes

Walking? □ No □ Yes

Negotiating stairs? □ No □ Yes

Communication (writing, typing, speaking, listening, etc.)? □ No □ Yes

Sensory function (hearing, seeing, feeling, tasting, or smelling)? □ No □ Yes

Hand activities (gripping, grasping, twisting, sensation, use of fingers, etc.)? □ No □ Yes

Sleep (change in your pattern of sleep or your ability to sleep)? □ No □ Yes

Travel (driving or riding in a car, plane, etc.)? □ No □ Yes

Performing housework? □ No □ Yes

Performing yard work? □ No □ Yes

Cooking? □ No □ Yes

Recreational activities? □ No □ Yes

Do you require the use of a handrail? □ No □ Yes

Do you require the use of any assistive devices (cane, crutch, walker, etc.)? □ No □ Yes

Previous Injuries / Injury History: Please list below all injuries you have had prior to this injury. Include dates and list time off work, if any. When all these items are not listed, it may appear that YOU concealed the information intentionally. You should include: *automobile accidents *childhood injuries/diseases *injuries you later recovered from *injuries resulting in broken bones *injuries requiring stitches *injuries with treatment by a chiropractor *any chiropractic visits (for any reason) *sports injuries *injuries that did not occur at work *any injury resulting in lost work time *slip and fall" accidents *prior work injuries

DATE	DESCRIBE THE INJURY/ACCIDENT AND BODY PART(S) AFFECTED	WORK RELATED? (YES OR NO)	TIME OFF WORK? (How long? Dates?)

List all prior hospitalizations, surgeries, or incidents that required hospital care:

_____

_____

_____

Have you received any past settlement awards? Yes No

If Yes, for which body part(s) and date(s) of injury?: _____

Date Received: _____ Amount: _____ Was this Workers' Compensation or Personal Injury? _____

Other Medical History:
Circle if you have the following condition(s). Write in any conditions you may have.

Respiratory: History of asthma, tuberculosis, wheezing, or hemoptysis.
Cardiovascular: History of high blood pressure, heart attack, or irregular heart beat.
Gastrointestinal: History of nausea, vomiting, indigestion, rectal bleeding, or ulcers.
Genitourinary: Change in urinary habits, venereal disease, or AIDS.
Endocrine: History of diabetes, thyroid disease, or other abnormalities.
Neuromuscular: History of congenital anomalies, fractures, or arthritis.
Psychological: History of psychiatric disease.
Neurological: History of seizures, epilepsy, or other problems.

Current Medications: Please list **all** medications you take, including those for medical conditions not related to this injury.

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Are you married? No ____ Yes ____ If No, have you been before? _____

Do you smoke? No ____ Yes ____ If Yes, how much / how often? _____

Do you drink? No ____ Yes ____ If Yes, how much / how often? _____

Do you use drugs? No ____ Yes ____ If Yes, how much / how often? _____

Education History:

High School: _____ Location: _____ years attended _____

College: _____ Location: _____ years attended _____

Degrees/Concentrations: _____ year of graduation ___

College: _____ Location: _____ years attended _____

Degrees/Concentrations: _____ year of graduation ___

Vocational Education: _____ years attended _____

Other Post High School Education:

Family Health History:

	Age	Health	List Health Problems	Age at death	Cause of death
Father					
Mother					
Brother(s)					
Sister(s)					
Son(s)					
Daughter(s)					

Work History: List **all jobs** you have had, from the most recent to the oldest. Use back of form if necessary.

Employer	Job Title/Duties	From - To

Name _____ Date _____

(Revision date May 2017)