Name:
DOB:
Chart:
Age:
Date:

OSNC
Orthopaedic Specialists of North County

INDUSTRIAL MEDICINE QUESTIONNAIRE

Name _____ Date _____

Right Handed _____ Age _____

Left Handed _____ Height _____

Weight _____

1. History of Injury

Date of Injury _____

Date last worked _____

Date you notified employer of your injury _____

Describe how you were injured: _____

2. Employment Data

Name of employer at time of injury _____

Address _____

Type of business _____

How long have you been working for this employer or date you were hired _____

Your job title _____

Briefly describe your work duties/activities _____

Give place of injury or address ☐ Same as above ☐ Other _____

Have you had any treatment or examination for this injury? ☐ No ☐ Yes

If yes, please list, in order, names of physicians or hospitals and treatment below

NAME	TREATMENT

Name:
DOB:
Chart:
Age:
Date:

List your present complaints/areas of pain caused by this injury: _____

_____

_____

Have you ever had any problems in this area of injury or similar injury in the past? ☐ No ☐ Yes

(If yes, briefly describe) _____

_____

_____

3. Work History

Did you lose any time from your job because of this injury? ☐ No ☐ Yes

At any time were you on modified/limited duty? ☐ No ☐ Yes

If you answer yes to either question above, list the dates you were unable to work or did modified work.

_____ to _____ ☐ Unable to work ☐ Modified

_____ to _____ ☐ Unable to work ☐ Modified

_____ to _____ ☐ Unable to work ☐ Modified

Are you back to work? ☐ No ☐ Yes Date Returned: _____

Same employer?* _____ Different employer? _____

*If no, why not? _____

_____

_____

List any previous work injuries _____

_____

Are you being retrained? _____

Past medical history _____

_____

_____

Past surgical history _____

_____

Allergies to medication _____

_____

Current medications _____

_____