GARO M. TERTZAKIAN, M.D., Q.M.E.

Workers' Compensation Patient Questionnaire

Name: _____ Date: _____

Age:_____ Sex: _____

HISTORY OF INJURY

Described how did the initial main injury/accident happen? Please be specific.

Did you finish the job you were doing at the time of the accident?

What were the immediate symptoms at the time of injury?

Did you report the injury or problem? **Yes / No**

If yes, when:_____ To whom: _____

HISTORY OF PRIOR OR SUBSEQUENT INJURIES

Have you had previous injuries to any parts of your body involved in this injury date? **Yes / No**
If yes, explain:

Have you ever had any other work-related injuries before? **Yes / No**
If yes, list dates and injuries:

Have you been in any motor vehicle accidents for which you received treatment: **Yes / No**

HISTORY OF TREATMENT

When did you first see a doctor after your injury? _____

To which hospital or clinic were you taken? _____

Were you sent by your employer? **Yes / No**

Name of the doctor(s) you saw?

_____

What type of doctor?

_____

Were tests done? **Yes / No**

X-rays _____ EMG _____ Nerve Tests _____ MRI _____ Ultrasounds _____

Other: _____

What did the tests show and what recommendations were made or what treatment was prescribed?

_____

_____

_____

_____

_____

a. Were you recommended to be off work? YES / NO (give dates)

_____

b. Hospitalized YES / NO (give dates)

_____

c. Physical therapy (give dates, how often)

_____

d. Casting: **Yes / No** Splinting: **Yes / No**

e. Was Surgery performed (what kind?

Give dates?)_____

_____

What other doctors have you seen for this injury?

_____

_____

Present treatment

Name of the doctor that you are currently seeing as your primary doctor for your work injury:

Has your doctor released you to return to work? **Yes / No**

If **YES**, Were you released to full duty or light duty? **Full / Light**

HISTORY OF UROLOGICAL COMPLAINTS

What type of urinary, testicular or (including sexual) problems are you been referred for?

When did you start having urinary, testicular or (sexual) problems?

Have you seen an urologist before for these problems? Yes / No

If yes give dates and name

Have you had any tests or surgery to evaluate/treat your urological symptoms?

Have you received any urological treatment before the accident?

JOB DESCRIPTION

Length of employment with employer at the time of your injury

Job title at the time of your injury: _____

Hours worked per day_____Days worked per week_____Overtime hours per week_____

Work duties (describe what you do during an average work day):

Maximum amount of weight that you would lift by yourself:

How many times per day would you have to lift this amount?

List any machines or tools that you routinely used at work:

Check any activities required in the course of your work:

Lifting _____ Carrying _____ Bending _____ Stooping _____

Squatting _____ Pushing _____ Pulling _____ Climbing _____

Walking _____ Sitting _____ Standing _____ Reaching Forward _____

Reaching Overhead _____ Awkward Positions _____ Other _____

Operate Equip._____ Exposure to chemicals or toxics? _____

Tools – Hand ____ Tools – Power _____ Repetitive Use _____

Number of years that you have worked for this employer: _____

Number of years that you have been in this line of work: _____

PREVIOUS WORK RECORD

List of previous employers and dates worked:

NAME_____ Years worked _____

NAME_____ Years worked _____

NAME_____ Years worked _____

NAME_____ Years worked _____

DO YOU HAVE MILITARY HISTORY

Yes ____ No _____ Army Navy Other _____

SOCIAL HISTORY

Check one of the following:

Married_____ Single_____ Divorced_____ Separated_____ Widow_____

Do you have any children? **Yes / No** If yes, how many _____ Ages? _____

Where were you born? _____

Have you attended trade school? **Yes / No**

If yes, what kind? _____

Are you able to perform any hobbies or activities: **Yes / No**

If yes described: _____

_____

Do you smoke? **YES / NO** Cigarettes per day? _____ For how long? _____

Do you drink alcohol beverages? **YES / NO** How often? _____ For how long? _____

Have you ever done any street drugs? **Yes / No**

If yes, what kind and how long ago? _____

Have you ever been in an alcohol or drug rehabilitation program? **Yes / No**

Date of Discharge _____

PAST MEDICAL HISTORY (before the date of injury)

Have you ever been hospitalized? **Yes / No**

If yes, list dates and reasons:

_____

_____

_____

_____

_____

_____

Have you ever had surgery for other condition not related to the injury? **Yes / No**

If yes, list date(s) and procedure(s):

_____

_____

_____

_____

Check any of the following conditions which you have now or had in the past:

Diabetes _____ Thyroid Problems _____ Rheumatoid Arthritis _____

Heart Attack_____ Stomach Ulcers_____ Tuberculosis_____

Cancer_____ Kidney Problems_____ High Blood Pressure_____

Stroke _____ Liver Disease Please List _____

Any other medical conditions:

1. _____ 2._____ 3._____

List of medications you are currently on with dosage and directions?

1. _____ 2._____ 3._____

4._____ 5._____ 6._____

7. _____ 8._____ 9._____

10._____ 11._____ 12._____

13. _____ 14._____ 15._____

List any allergies your may have? (Include food allergies)

1. _____ 2._____ 3._____

4._____ 5._____ 6._____

7. _____ 8._____ 9._____

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Questions for female patients only

1. When was your last menstrual period?_____ are they normal? **Yes / No**

If no described_____

2. How many pregnancies have you had? _____

3. Were they all full term? _____

4. Were they delivered normal ( ) or via cesarean ( ).

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PATIENTS INITIALS: _____ DATE: _____

GARO M. TERTZAKIAN, M. D.
WORKER'S COMPENSATION PATIENT INFORMATION

NAME: _____: SSN (needed for billing)_____:
(Nombre) Last name First Middle Initial

ADDRESS: _____City _____ State ____Zip code _____

CELL#: _____: OTHER PHONE: _____: E-mail_____

DATE OF BIRTH: _____; Married ____Single _____Divorce_____ Other _____

DATE OF INJURY: _____: Primary Doctor for your injury: _____:

RELATIVE OR FRIEND TO CALL IN CASE YOU CAN'T BE REACHED (or other phone number)

NAME_____PHONE; _____

****

EMPLOYER INFORMATION AT TIME OF INJURY:

COMPANY NAME: _____:

ADDRESS: _____:CITY: _____: STATE: _____: ZIP CODE: _____

JOB TITLE AT TIME OF INJURY: _____

****

WORKER'S COMP INSURANCE INFORMATION:

NAME: _____

ADDRESS: _____

PHONE: _____; Adjuster name: _____

CLAIM NUMBER: _____: WCAB /ADJ#: _____.

****

INFORMATION OF ATTORNEY FOR YOUR WC CASE:

NAME; _____: PHONE: _____;

ADDRESS; _____

PATIENT'S SIGNATURE; _____DATE: _____: