BAY AREA ORTHOPEDIC
SURGERY & SPORTS MEDICINE

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QME / AME / IME QUESTIONNAIRE

Name:			Date
Right Handed _____ Left Handed _____	Age?	Height?	Weight?
Dates of injury(ies) for which you are being seen:	Body Part(s):	Employer and Job Title:	Have you had problems with any of these body parts before this injury?
1.			□ Yes □ No
2.			□ Yes □ No
3.			□ Yes □ No

OCCUPATIONAL HISTORY

Employer (***At Time of Injury***) Job Title: _____	**Starting date:** _____ If not still employed there. **Ending date:** _____
Job Responsibilities (At Time of Injury)	

PHYSICAL DEMANDS OF JOB (***at the time of injury***)

	Not at all	**Up to 1/3 of the day**	**Up to 2/3 of the day**	**Over 2/3 of the day**
Sit in Chair				
Type/Keyboard				
Drive				
Stand In One Place				
Walk				
Walk On Uneven Ground				

Climb				
Grip				
Reach				
Reach Overhead				
Twist				
Stoop				
Bend				
Squat				
Crawl				
Push/Pull				
Kneel				

Lift Less Than 10 Pounds				
Lift 10-25 Pounds				
Lift 25-50 Pounds				
Lift 50-75 Pounds				
Lift 75-100 Pounds				
Lift 100 Pounds				

Are you currently working full duty or light duty? □ Full Duty □ Light Duty □ Off Work

If you are not working, date you last worked: _____

Has your doctor said you cannot return to the job you had when you got hurt? □ Yes □ No

What type of disability payments did you receive? _____

What were the starting and ending dates of the disability payments? Start_____ End_____

Have you applied for or are you receiving Social Security Disability? □ Yes □ No

Were you working two or more jobs for other employers **at the time of your injury**? □ Yes □ No

If yes, please list name of the other employer: _____

If yes, please describe the work you are doing: _____

_____

_____

Did you return to work for a different employer, participate in volunteer work or become self-employed **after the injury**?

If yes, please list the name of the different employer: _____

If yes, please describe the work you are doing: _____

_____

_____

PAST EMPLOYMENT HISTORY

Name of Past Employer	Job Title	Starting Date	Ending Date

HISTORY OF CURRENT INJURY (For Which You Are Being Seen Today)

How did you get hurt? _____

_____

_____

What body parts did you hurt? ? _____

_____

What were your initial symptoms or complaints? _____

_____

_____

On what date did you report the injury? _____

To whom did you report your work injury? _____

Has your claim been accepted by the workers' compensation carrier? □ Yes □ No

FIRST TREATMENT

Who was the first doctor you saw or at what facility did you seek treatment? _____

What tests/x-rays were done? _____

What medications were prescribed? _____

Were you referred for physical therapy or other treatment? □ Yes □ No

Was surgery recommended? □ Yes □ N

Did you receive the treatment and/or surgery? □ Yes □ No

Did you return to work after this treatment? □ Yes □ No

SECOND DOCTOR & TREATMENT

Who was the next doctor you saw? _____

What tests/x-rays were done? _____

What medications were prescribed? _____

Were you referred for physical therapy or other treatment? □ Yes □ No

Was surgery recommended or performed? □ Yes □ No

Did you receive the treatment and/or surgery? □ Yes □ No

Did you return to work after this treatment? □ Yes □ No

This doctor's opinion as you understand it: _____

_____

_____

THIRD DOCTOR & TREATMENT

Who was the next doctor you saw? _____

What tests/x-rays were done? _____

What medications were prescribed? _____

Were you referred for physical therapy or other treatment? □ Yes □ No

Was surgery recommended or performed? □ Yes □ No

Did you receive the treatment and/or surgery? □ Yes □ No

Did you return to work after this treatment? □ Yes □ No

This doctor's opinion as you understand it: _____

_____

_____

CURRENT TREATMENT

Who is your current primary treating physician? _____

Are you receiving treatment at this time? □ Yes □ No

What treatment have you received (please circle):

Physical Therapy	Home Exercise Program
Acupuncture	Work Hardening program
Chiropractic care	Functional Capacity Evaluation
Interventional Injections	Use of Supportive Device Such as Cane/Brace
TENS unit	

I am currently scheduled to receive treatment as follows: _____

_____

Current Medications (for the injury you are being seen for today)

Name of Medication

Past Medications (for the injury you are being seen for today)

Name of Medication

PAST INJURY HISTORY

Please circle any bodily injuries **BEFORE** or **AFTER** the injury for which you are being seen today and include injuries that are **sports related**, **slips and falls**, **home accide**nts, **military accidents**.

Please ask for additional sheets if there are more than two past injuries.

PAST Injury #1: What was the date when you first experienced symptoms of another injury?	Date of Injury_____ Work related? □ Yes □ No Other _____

What body parts did you hurt? _____

What were your initial symptoms or complaints? _____

_____

_____

How did you get hurt? _____

_____

_____

Please list the name of the doctors you saw for this injury: _____

_____

Please **circle** the types of medical treatment you received for this injury.

Physical Therapy	Acupuncture	Medication
Occupational Therapy	CT scan	X-rays
Myelogram	MRI	Cortisone Injections
Chiropractic Care	Psychological Treatment	EMG/Nerve Conduction Study

Was surgery recommended or performed? □ Yes □ No

Were you able to resume your usual and customary job duties after this injury? □ Yes □ No

If this was a work-related injury, what was the name of your employer? _____

Did you file a workers' compensation claim? ? □ Yes □ No

If applicable, how did you settle this injury claim? _____

What was the level of permanent disability awarded to you? _____

What was the total amount of settlement? _____% $_____

PAST Injury #2: What was the date when you first experienced symptoms of another injury?	Date of Injury_____ Work related? □ Yes □ No Other _____

What body parts did you hurt? _____

What were your initial symptoms or complaints? _____

_____

_____

_____

How did you get hurt? _____

_____

_____

_____

Please list the name of the doctors you saw for this injury: _____

_____

_____

Please **circle** the types of medical treatment you received for this injury:

Physical Therapy	Acupuncture	Medication
Occupational Therapy	CT scan	X-rays
Myelogram	MRI	Cortisone Injections
Chiropractic Care	Psychological Treatment	EMG/Nerve Conduction Study

Was surgery recommended or performed? □ Yes □ No

Were you able to resume your usual and customary job duties after this injury? □ Yes □ No

If this was a work-related injury, what was the name of your employer? _____

Did you file a workers' compensation claim? ? □ Yes □ No

If applicable, how did you settle this injury claim? _____

What was the level of permanent disability awarded to you? _____

What was the total amount of settlement? _____% $_____

HEALTH HISTORY

Do you have allergies to medications? □ Yes □ No

If yes, please list? _____

Did you have any serious childhood illnesses or injuries? □ Yes □ No

If yes, please describe: _____

_____

_____

Please list any prior hospitalizations or surgeries unrelated to this injury: _____

_____

_____

Do you smoke? □ Yes □ No

Please **circle** any conditions for which you have been treated in the past.

Myalgias	Arthralgias	Systemic Arthritis	Arthritis	Fibromyalgia	Gout
Blood/Hematology Disorders		Cancer	Collagen Disease	Coronary Artery Disease	Diabetes Mellitus
Ear Nose & Throat Disorders,	Epilepsy	Genital and Urinary Disorders	Hepatitis	Hypercholesterolemia	Hypertension
Immunologic Disorders	Lung Disease	Lymphatic Disorders	Respiratory Disorders	Skin Disorders	

PLEASE CONTINUE ON NEXT PAGE

CURRENT SYMPTOMS

Symptoms for Body Part #1	**What makes it better?** (Please Circle)	**What makes it worse?** (Please Circle)
Body Part: _____ Numbness/Tingling Swelling Grinding Snapping Popping Locking Cramps Muscle Spasms Stiffness Decreased Range of Motion Giving Way Falling Weakness Hand grip Radiation from _____ to _____ Bowel/bladder/sexual dysfunction	Hot Packs Ice Packs Physical Therapy Changing Positions Rest Temporary Disability Light Duty Prescribed Medications TENS Unit Splints Cane Braces	Reaching at Chest Level Reaching Overhead Pushing-Pulling Activities Lifting and Carrying Heavy Objects Reaching, Gripping Grasping, Holding, Manipulating Objects Doing Forceful Activities With the Arms Performing Data Entry Lifting And Carrying Heavy Objects Ascending and Descending Stairs Standing or Walking For Extended Periods of Time Kneeling Bending Squatting Sitting for Prolonged Periods of Time Stooping Coughing Sneezing and Bearing Down. Traveling Cooking Doing Laundry Housekeeping Shopping Yardwork

Symptoms for Body Part #2	**What makes it better?** (Please Circle)	**What makes it worse?** (Please Circle)
Body Part: _____ Numbness/Tingling Swelling Grinding Snapping Popping Locking Cramps Muscle Spasms Stiffness Decreased Range of Motion Giving Way	Hot Packs Ice Packs Physical Therapy Changing Positions Rest Temporary Disability Light Duty Prescribed Medications TENS Unit Splints Cane Braces	Reaching at Chest Level Reaching Overhead Pushing-Pulling Activities Lifting and Carrying Heavy Objects Reaching, Gripping Grasping, Holding, Manipulating Objects Doing Forceful Activities With the Arms Performing Data Entry Lifting And Carrying Heavy Objects Ascending and Descending Stairs Standing or Walking For Extended Periods of Time Kneeling Bending

Symptoms for Body Part #2	**What makes it better?** (Please Circle)	**What makes it worse?** (Please Circle)
Falling Weakness Hand grip Radiation from _____ to _____ Bowel/bladder/sexual dysfunction		Squatting Sitting for Prolonged Periods of Time Stooping Coughing Sneezing and Bearing Down. Traveling Cooking Doing Laundry Housekeeping Shopping Yardwork

Symptoms for Body Part #3	**What makes it better?** (Please Circle)	**What makes it worse?** (Please Circle)
Body Part: _____ Numbness/Tingling Swelling Grinding Snapping Popping Locking Cramps Muscle Spasms Stiffness Decreased Range of Motion Giving Way Falling Weakness Hand grip Radiation from _____ to _____ Bowel/bladder/sexual dysfunction	Hot Packs Ice Packs Physical Therapy Changing Positions Rest Temporary Disability Light Duty Prescribed Medications TENS Unit Splints Cane Braces	Reaching at Chest Level Reaching Overhead Pushing-Pulling Activities Lifting and Carrying Heavy Objects Reaching, Gripping Grasping, Holding, Manipulating Objects Doing Forceful Activities With the Arms Performing Data Entry Lifting And Carrying Heavy Objects Ascending and Descending Stairs Standing or Walking For Extended Periods of Time Kneeling Bending Squatting Sitting for Prolonged Periods of Time Stooping Coughing Sneezing and Bearing Down. Traveling Cooking Doing Laundry Housekeeping Shopping Yardwork

CURRENT PAIN STATUS

I. Pain (Self-Report of Severity)

A. Rate how severe your pain is right now, **at this moment** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain you can imagine

B. Rate how severe the pain is **at its worst** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how severe your pain is **aggravated by activity** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

E. Rate how **frequently** you experience pain (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Rarely — All the time

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not prevent lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to stand for 1/2 hour — Unable to stand for 1/2 hour

E. How much does your pain interfere with your ability to **get enough sleep?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car?**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you limit your activities to prevent your pain from **getting worse?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

J. How much does your pain interfere with your relationship with your **family/partner/significant others?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not prevent lifting 10 pounds — Impossible to lift 10 pounds

K. How much does your pain interfere with your ability to **do jobs around your home?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to stand for 1/2 hour — Unable to stand for 1/2 hour

M. How much does your pain interfere with your ability to **write or type?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

N. How much does your pain interfere with your ability to **dress yourself?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

O. How much does your pain interfere with your ability to **engage in sexual activities?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

P. In general, how much does your pain interfere with your **ability to concentrate?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week how **anxious or worried** have you been because of your pain? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious /worried are you about performing activities because they **might make your pain/symptoms worse?** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

SOCIAL STATUS

How many years of schooling have you completed? _____

What are the ages of your children? _____

ACTIVITY STATUS

What were your hobbies/recreational activities before the injury? **Please circle:**

Socializing Watching Television Shopping Going to the Park Family Outings

Spending Time With Family and Friends Other_____

Do you participate in these activity now? □ Yes □ No _____

Are you a member of a gym or health club, such as YMCA, or 24-Hour Fitness? □ Yes □ No

If yes, what is the name of the gym or health club?

Do you do a home exercise program? □ Yes □ No

Please **circle** the home exercises you do:

Abdominal Machine/Exercise	Calisthenics	Hand Weights	Treadmill Exercise	Yoga
Aerobics	Dumbbells	Pilates Training	Weight/Resistance Machines	Other:
Barbells	Elliptical Motion Trainer	Stretching	Weight Training	Other:

Do you participate in sports? □ Yes □ No

If yes, what are those sports? _____

Do you own or operate a motorcycle, snowmobile, boat or all-terrain vehicle? □ Yes □ No

Do you live on a large amount of property? □ Yes □ No