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WORKERS' COMPENSATION HISTORY

Please complete this form as thoroughly as possible. This information is needed to provide a detailed report of your injury(ies). Failure to provide the requested information could delay the report and any additional medical care that you might need. **Fraudulent information is against the law.**

Patient Name: _____ Today's date: _____

DOB: _____ AGE: _____ Right Handed Left Handed Ambidextrous

Who referred you to this office? _____

Please list any current medications: _____

List any allergies to foods or medications: _____

Please list any operations (and dates) you have ever had: _____

Have you been hospitalized within the last 10 years? Yes No Why? _____

Past Medical History: Please check the "yes" or "no" box to indicate if **you** have any of the following illnesses.

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Clotting problem	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Lung clots	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

Family History: Please Check the “yes” or “no” box to indicate whether **any relatives** have any of the following illnesses. If yes, please indicate which relative(s) have the problem.

	Yes	No	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History:

Place of birth? _____

Education completed? _____

What is your occupation? _____

Work status: Working Retired Disabled Student Unemployed Homemaker

Other: _____

Marital status: Single Married Separated Divorced Widowed other: _____

Number of children: _____ Ages: _____

	Yes	No		
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____	How long? _____
Do you drink?	<input type="checkbox"/>	<input type="checkbox"/>	How much? _____	How often? _____
Sports or exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____	

Review of Systems:

Please check the “Yes” or “No” box to indicate if you are experiencing any of the following symptoms:

		Yes	No		Yes	No
GENERAL:	Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>
	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>			
ENT:	Ringing of ears	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
EYES:	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Eye itching	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS:	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>
	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC:	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>
	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>
	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
GASTRO:	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>
	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Black or tarry stools	<input type="checkbox"/>	<input type="checkbox"/>
SKIN:	Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>
NEURO:	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Balance problems	<input type="checkbox"/>	<input type="checkbox"/>
	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Loss of coordination	<input type="checkbox"/>	<input type="checkbox"/>
	Tremors/shaking	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
GU:	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>	Delayed urination	<input type="checkbox"/>	<input type="checkbox"/>
	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Urinating at night	<input type="checkbox"/>	<input type="checkbox"/>
	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>			
ENDO:	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>
	Tired /sluggish	<input type="checkbox"/>	<input type="checkbox"/>	Too cold or too hot	<input type="checkbox"/>	<input type="checkbox"/>
	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
HEMA:	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting prob.	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH:	Depression	<input type="checkbox"/>	<input type="checkbox"/>	High stress levels	<input type="checkbox"/>	<input type="checkbox"/>
	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
	Suicidal ideations	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY:	Jewelry stains	<input type="checkbox"/>	<input type="checkbox"/>	Metal intolerance	<input type="checkbox"/>	<input type="checkbox"/>

Job Description

- 1. Employer at the time of injury: _____
- 2. How long had you worked there at the time of this injury? _____
- 3. Job title: _____
- 4. Number of hours per day: _____ How many days per week? _____
- 5. Describe your work duties at the time of injury: _____
- 6. Describe your physical demands to perform this job: _____
- 7. Estimate the amount of weight you lifted during the day: _____ How often? _____
- 8. Estimate the amount you lifted with co-workers during the day: _____ What did you routinely have to lift by yourself or with co-workers? _____
- 9. Did you work somewhere else at the same time you worked for this employer? Yes No
- 10. How long did you work at both places at the same time? _____
- 11. If yes where did you work? _____
- 12. If yes what were your duties? _____

WORK STATUS:

- 13. Were you able to work after the accident? Yes No
- 14. Are you currently working? Yes No When did you return to work? _____
- 15. If you missed work, how many days? _____
- 16. Are you working for the same employer? Yes No
- 17. Have you been gainfully employed elsewhere after your injury or disability? Yes No
- 18. Are you doing the same work or modified duties? _____
- 19. What are your new duties? _____
- 20. Name of current employer: _____

Prior accident history

- 21. Did you have any problems to these body parts before this particular injury occurred?
 Yes No Explain: _____
- 22. Have you ever had any injuries to this area(s)? Yes No When? _____
- 23. Have you ever been involved in a car accident? Yes No When? _____
- 24. Did you miss any time from work then? Yes No How long? _____
- 25. Have you applied for Social Security benefits? Yes No
- 26. Are you receiving Social Security benefits? Yes No Since when? _____
- 27. Are you receiving VA benefits? Yes No Since when? _____
- 28. Are you receiving any retirement benefits? Yes No Since when? _____
- 29. Are you receiving long term disability benefits? Yes No Since when? _____

Prior work-related injuries

30. Ever filed any worker's comp. claims? Yes No
Give details: _____
31. Were you given any disability rating? Yes No Rating: _____
32. Did you receive any settlements? Yes No Amount: _____
33. Did you miss any time from work? Yes No Time missed: _____

Previous Complaints

34. Have you ever had any previous similar problems? Yes No Explain: _____

Subsequent Accident

35. Have you been involved in any subsequent accident? Yes No
Describe: _____
36. Been involved in any car accidents after this injury? Yes No
Describe: _____

HISTORY OF INDUSTRIAL INJURY

37. Your occupation at the time of injury? _____
38. Who was your employer at that time? _____
39. Length of time worked there prior to accident: _____
40. What was the date(s) of the injury (ies)? _____ Hour _____ AM/PM
41. If there is no specific date of injury, when did you first begin to have problems? _____

42. How did the injury occur? _____

43. What part(s) of your body were injured? _____
44. Was this a witnessed accident? Yes No By whom? _____
45. Did you finish what you were doing? Yes No
46. Did you report your injury? Yes No To whom? _____
47. When did you report it? _____
48. Did you fill out a form? Yes No Don't know
49. Where did you first seek care for this condition? _____
50. When did you first seek care? Same day Next day Other: _____
51. Who sent you there for treatment? Employer Insurance Friend Yourself

52. Explain in detail any and all treatment received the first time: _____

53. Did you go to the emergency room or urgent care? Yes No Facility: _____

54. How did you get there? Ambulance Drove yourself Family or friend drove you

55. What care was provided at the ER or Urgent Care? _____

56. Did you have or did you receive? Check all that apply:

- X-rays CT Scans EMG MRI Bone Scan Braces/splints
 Injections Therapy Blood test Stitching Crutches Drug screening

57. Were you hospitalized at any time as a consequence of the injuries you sustained from the accident?

Yes No Name of hospital/city/state: _____

Date admitted: _____ Date discharged: _____

Treating physician: _____

58. Have you been seen at a Clinic or doctor's office for this condition? Yes No

59. Where and when were you seen? _____

60. Who sent you there for treatment? Employer Insurance Friend Yourself

61. Explain in detail any and all treatment received at this facility: _____

62. What were you told was wrong? _____

63. Have any of the following tests been performed for this condition? Check all that apply:

- X-rays MRI Bone Scan Indium Scan Blood test
 CT Scan EMG Ultrasound Arthrogram
 Other: _____

64. Where were these tests performed? _____

65. What treatment has been provided for this condition? Check all that apply:

- Medications Injections Therapy Braces/splints Exercise program
 Casting Crutches Surgery Acupuncture Other: _____

66. Where did you receive the treatment? _____

67. Have any surgeries been performed for this condition? Yes No Explain: _____

68. Were you helped by the surgery (ies)? Yes No Explain: _____

69. Did any of the treatment help? _____

70. If yes, what helped you? _____

71. List all other physicians you have seen for this injury. (Write in the back of the page is necessary)

Dr: _____ Specialty: _____ Date seen: _____

Who referred you to him? Employer Insurance Attorney Yourself

Type of evaluation: Treater Consult Second Opinion AME QME

Tests performed (Circle all that apply): X-rays CT Scans EMG MRI Bone Scan

Other: _____

Treatment given: X-rays Medications Braces/splints Injections Therapy Surgery

Surgery: _____

Additional treatment: _____

Did any treatment help? _____ If yes, what helped? _____

What were you told was wrong? _____

Dr: _____ Specialty: _____ Date seen: _____

Who referred you to him? Employer Insurance Attorney Yourself

Type of evaluation: Treater Consult Second Opinion AME QME

Tests performed (Circle all that apply): X-rays CT Scans EMG MRI Bone Scan

Other: _____

Treatment given: X-rays Medications Braces/splints Injections Therapy Surgery

Surgery: _____

Additional treatment: _____

Did any treatment help? _____ If yes, what helped? _____

What were you told was wrong? _____

CURRENT MEDICAL COMPLAINTS

72. Do you have any pain? Yes No Where is it? _____

73. What does it feel like? (Sharp, dull, burning, pins, needles, stabbing, etc.) _____

74. How often do you experience pain?

Less than ¼ of the day ¼ of the day ½ of the day ¾ of the day All day

75. On a scale from 1-10, with 1 being the mildest and 10 being the highest, rate the severity of your pain?

1 2 3 4 5 6 7 8 9 10

76. Does your pain travel to other body parts? Yes No Where? _____

77. What activities cause you to have pain? Coughing Sneezing Sitting Turning neck

Standing Bending Stooping Twisting Walking Stairs Uneven terrain

Kneeling Squatting Pivoting Inclines Running Jumping Working out

Sports Footwear Lifting Pushing Pulling Gripping Grasping

Torquing Reaching Throwing Driving Cold Vibration Keyboarding

Other: _____

78. What relieves your pain? Resting Icing Heat Creams Medications
 Stretching Massage Bracing Splinting Therapy Acupuncture
 Other: _____

79. Do you have any urinary or bowel incontinence? Yes No Explain: _____

80. Do you have any hand numbness or tingling at night? Yes No

81. Which fingers normally tingle or go numb? _____

82. Does pain wake you up? Yes No How often? _____

83. Is there any stiffness? Yes No Where? _____

84. Is there any weakness? Yes No Where? _____

85. Is there any numbness? Yes No Where? _____

86. Is there any tingling? Yes No Where? _____

87. Any locking in joints? Yes No Where? _____

88. Any popping of joints? Yes No Where? _____

89. Any giving way of joints? Yes No Where? _____

90. Any grinding of joints? Yes No Where? _____

91. Is there any swelling of joints? Yes No Where? _____

92. Any deformity of joints? Yes No Where? _____

93. Any instability of joints? Yes No Where? _____

94. Do you have any limitations in your activities of daily living based on this injury? Yes No

Explain: _____

95. What activities are you unable to perform because of this injury? _____

96. How does this condition affect your capacity to work? _____

97. Do you need any accommodations to return to work? Yes No Explain: _____

98. What is the disability resulting from this injury? _____

Patient's signature: _____ Date: _____

Interpreter's signature: _____ Date: _____

Authorizing signature: _____ Relationship: _____