MEDICAL HISTORY QUESTIONNAIRE

EMPLOYEE		EMPLOYER	
DATE OF INJURY	FILE NUMBER	SOCIAL SECURITY NO.	DATE OF BIRTH

PERSONAL PHYSICIAN NAME & ADDRESS

	YES	NO
1. HAVE YOU EVER:		
a. Claimed or received Workers' Compensation Benefits? If YES, when, for what, name and address of treating doctors		
b. Claimed or received disability benefits? If YES, when, for what, name and address of treating doctors		
c. Recieved a Compensation or Disability rating for an off the job injury?		
d. Received military medical discharge?		
e. Been rejected for military service?		
f. Been hospitalized?		
g. Been in or treated at any hospital, sanitarium or other institution for observation, rest, diagnosis or treatment? If YES, explain		
h. Been refused employment for physical reasons? If YES, give details		
i. Been refused or given up a job for health reasons?		
2. HAVE YOU EVER:		
a. Had a serious illness? If YES, give details		
b. Had a serious injury? If YES, give details		
c. Had an automobile or motorcycle related injury or athletic injury? If YES, give details		
d. Had surgery? If YES, give details		
e. Had back trouble or a back injury or backaches, sciatica or neuritis? If YES, give details		
f. Had neck trouble or a neck injury or neck aches? If YES, give details		
g. Had a hernia or rupture? If YES, give details		
h. Had a head injury? If yes, give details		
i. Worn a hearing aid? Do you have any hearing trouble?		
j. Had any nerve trouble?		

3. HAVE YOU EVER:

		YES	NO
a.	Had arthritis?		
	If YES, give details		
b.	Had bone or joint trouble or a bone or joint injury?		
c.	Had tuberculosis?		
d.	Had kidney trouble?		
e.	Had diabetes?		
f.	Had heart trouble? A heart attack, chest pains or rheumatic heart disease?		
g.	Had high blood pressure?		
h.	Had thyroid problems?		
i.	Had epilepsy, fainting spells, dizziness, anemia or fatigue?		
j.	Had convulsions?		
k.	Had asthma, emphysema, bronchitis or respiratory problems?		
l.	Do you smoke? If YES, how much, how long have you been a smoker?		
m.	Had rheumatism or rheumatic fever?		
n.	Had varicose veins or circulatory problems?		
o.	Had allergies?		
p.	Had chronic cough?		
q.	Had jaundice or gallbladder disease?		
r.	Had paralysis?		
s.	Had knee injury, prior broken bones or sprains of any extremity, including hands, feet, arms, legs and fingers?		
t.	Had ulcers or stomach or intestinal problems?		
u.	Had skin trouble?		
v.	Had amputation of any part of the body?		
w.	Had alcoholism or drug addiction?		
x.	Had cancer?		
y.	Had depression, mental illness, nervous breakdown or psychiatric treatment?		

4. PLEASE ANSWER THE FOLLOWING:

		YES	NO
a.	Are you under a doctor's care or taking medication at this time?		
	If YES, give details		
b.	Do you have physical limitations?		
	If YES explain		
c.	Do you have a family doctor? Please list name and address.		
d.	Please list the name and address of any former physicians.		
e.	Have you ever had a cardiogram (for your heart)?		
	If YES, when, where and what for?		
f.	Have you ever had an EEG (brain)?		
	If YES, when, where and what for?		

g. Your height _____

h. Your weight _____