MEDCARE OCCUPATIONAL HEALTH

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PATIENT ID / RECORD # _____

Orthopedic History Questionnaire

FORM MC-103

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

PRESENT OCCUPATION | COMPANY

MUSCULOSKELETAL HISTORY

Have you ever had pain in, or injured, any of the following?

BODY AREA	INJURED?	WHERE DID IT HAPPEN?	DATES, TREATMENT GIVEN, HOW LONG IT PERSISTED
Neck	☐ YES ☐ NO	☐ Home ☐ Work	
Shoulder	☐ YES ☐ NO	☐ Home ☐ Work	
Back	☐ YES ☐ NO	☐ Home ☐ Work	
Hand	☐ YES ☐ NO	☐ Home ☐ Work	
Knee	☐ YES ☐ NO	☐ Home ☐ Work	
Foot	☐ YES ☐ NO	☐ Home ☐ Work	

ORTHOPEDIC CARE & RESTRICTIONS

Have you ever had surgery on your back, neck, or other orthopedic surgery? ☐ YES ☐ NO

Date(s): _____ *Type of surgery:* _____

Are you currently taking any medication for a back, neck or other orthopedic injury? ☐ YES ☐ NO

Medication(s): _____

Are you currently under the care of a physician, physical therapist, chiropractor, or pain management specialist? ☐ YES ☐ NO

Provider name: _____ *Provider phone:* _____

Have you had any restrictions placed on you, current or past, due to a back, neck or other orthopedic injury? ☐ YES ☐ NO

Please list: _____

Have you experienced numbness or tingling, current or past, in your upper or lower extremities due to an injury? ☐ YES ☐ NO

Please explain: _____

I understand that failure to answer truthfully may result in the denial of compensation benefits, including medical treatment and expenses. I hereby certify that the information provided above and the information which I will provide to the medical provider in connection with this examination is true and correct to the best of my knowledge. I understand that any omission of fact or false statement is sufficient grounds for denial of employment or, if employed, termination of my employment.

EMPLOYEE SIGNATURE _____

DATE _____