

Orthopedic History Questionnaire

FORM MC-103

FIRST NAME	LAST NAME	SSN / EMPLOYEE ID
DATE OF BIRTH	AGE	SEX
		☐ Male ☐ Female
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 & RESTRICTIONSHave 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