

**INDUSTRIAL MEDICINE QUESTIONNAIRE**

**LA JOLLA SPORTS ORTHOPAEDIC & KNEE  
SURGERY MEDICAL GROUP INC.**

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Diplomate American Board of Orthopaedic Surgery

Name \_\_\_\_\_.

Date: \_\_\_\_\_.

Right Handed: \_\_\_\_\_.

Age: \_\_\_\_\_.

Left Handed: \_\_\_\_\_.

Height: \_\_\_\_\_.

Weight: \_\_\_\_\_.

**I. HISTORY OF INJURY**

Date of injury \_\_\_\_\_.

Date last worked \_\_\_\_\_.

Date employer was notified of the injury \_\_\_\_\_.

Describe how you were injured \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**II. EMPLOYMENT DATA**

Name of employer at time of injury \_\_\_\_\_

Address \_\_\_\_\_

Type of business \_\_\_\_\_.

How long have you been working for this employer or  
date you were hired \_\_\_\_\_.

Job title \_\_\_\_\_

Briefly describe your work duties/activities \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Give place of injury or address  
same as above \_\_\_\_\_

Other: \_\_\_\_\_

Have you had any treatment or examination for this injury?  
and/or hospitals and treatment.

No \_\_\_ Yes \_\_\_ If yes, please list in order names of physicians

NAME	TREATMENT

List present complaints/areas of pain caused by this injury

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Have you ever had any problems in this area of injury or  
similar injury in the past?

No \_\_\_ Yes \_\_\_ If yes, please briefly describe

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### III WORK HISTORY

Did you lose any time from your job because of this injury?

No \_\_\_ Yes \_\_\_.

At any time were you on modified/limited duty? No \_\_\_ Yes \_\_\_.

If you answered yes to either question above, list the dates  
you were unable to work or did modified work.

Unable to Work	Modified
to	
to	
to	

Are you back to work? No \_\_\_ Yes \_\_\_ Date returned \_\_\_.

