

John H. Serocki, M.D.

A Professional Corporation

Diplomate American Board of Orthopaedic Surgery

Sports Medicine Orthopaedic Surgeon – Surgery of the Shoulder, Hand and Knee

9834 Genesee Avenue • Suite 228 • La Jolla, CA 92037
(858) 824-1703 • FAX (858) 455-6473

1763 West 24th Street • Suite 105 • Yuma, AZ 85364
(928) 344-4575 • FAX (928) 344-0577

WWW.LJSO.ORG

E-MAIL: jserockimd@ljsso.org

Industrial Injury Questionnaire

Patient: _____

Date : _____

Age: _____

Height: _____

Weight: _____

Dominant Hand:

Left

Right

Occupation: _____

Employer: _____

Date of injury: _____

Date employer notified: _____

Date last worked: _____

If you are on light duty, what date did you start light duty?: _____

If you are not working, what was the day you last worked?: _____

Are you still working for the same employer? Yes No – If No, date you separated from employer _____

What symptoms or Injury are you having and when did they begin?:

How did you get injured?

Have you had any treatment for this injury?

Have you had any prior or previous injury to these areas?

Describe your work duties:

List any previous surgeries including the date(s) done

Surgery: _____ Date: _____ Work Related ? Y N
 Surgery: _____ Date: _____ Work Related ? Y N
 Surgery: _____ Date: _____ Work Related ? Y N

Medications – List any regular medications and those specific to this injury:

Med Name: _____ Dose: _____ How Often?: _____
 Med Name: _____ Dose: _____ How Often?: _____
 Med Name: _____ Dose: _____ How Often?: _____

Allergies: - please list any drugs and/or substances and what your reaction to it is (include Anti Inflammatory medications such as Aleve or Motrin) - Any Allergies to medication? Yes ___ No ___

Substance: _____ Reaction: _____
 Substance: _____ Reaction: _____
 Substance: _____ Reaction: _____

List any serious accidents or injuries you have or have had

Type: _____ Date: _____
 Type: _____ Date: _____
 Type: _____ Date: _____

Circle or List any medical conditions that you have or have previously had

Heart Attack / MI	Rheumatoid Arthritis	Neurological Disease	Gastritis or Ulcers
Cardiac Disease	Gout	Recurrent Headaches	Thyroid Disease
Heart Disease	Osteoarthritis	Recent Weight Loss	Liver Disease
Mitral Valve Prolapse	Blood Clots	Constant Night Pain	Polio
Emphysema	High Blood Pressure	Fever or Chills	Tuberculosis
Stroke	Anemia	Depression	Fibromyalgia
Epilepsy	Diabetes		Hepatitis
Enlarged Prostate	Asthma		Alcohol Abuse
			Drug Abuse
Other:			HIV/AIDS

Do you smoke? No Yes – How much and for how long? _____

Do you drink alcohol? No Yes – How much and for how often? _____

Please describe any leisure activities, including sports or athletic, that you participate in:

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WORKER'S COMPENSATION SUPPLEMENTAL HISTORY

Patient: _____ **DOB:** ____/____/____

Date of injury _____

Date last worked _____

Name of employer _____

Type of business _____

How long have you worked for this employer _____

Job title _____

Describe work duties & activities _____

If you are not working, what was the day you last worked? _____

If you are on light duty, what date did you start light duty? _____

Did injury occur at employer's place of business? Yes _____ No _____

If yes, exact place at work where you were injured (ex: break room, parking lot, etc.)

If no, where? _____

Are you still working for the same employer? Yes _____ No _____

If no, why? _____

Patient/Guardian Signature _____ **Date** _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS AND/OR FAMILY MEMBERS

In accordance with Federal Government Privacy rules implemented through the Health Information Portability and Accountability Act (HIPAA), in order for your physician or staff to discuss your medical information with members of your family or other individuals you designate, we must obtain your authorization prior to doing so. In the event of an emergency or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. You have the option to decline the release of this information. Please indicate your preference below.

_____ Yes, I authorize the practice to verbally release any and/or all information concerning my medical care to any family member.

_____ Yes, I authorize the practice to verbally release any and/or all information concerning my medical care on any personal answering machine and/or voice mail system.

_____ No, I do not authorize the practice to verbally release any and/or all information concerning my medical care to any family member.

_____ No, I do not authorize the practice to verbally release any and/or all information concerning my medical care on any personal answering machine and/or voice mail system.

AUTHORIZATION TO OBTAIN MEDICAL RECORDS FROM MEDICAL PROVIDERS

By my signature below, I here by authorize John H. Serocki, M.D. and his staff to **OBTAIN** any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past. This would include receiving these records via facsimile and other secure electronic communication channels.

I understand that it may become necessary For John H. Serocki, M.D. and his staff to **DISCLOSE** treatment, billing or medical information to referring physicians, hospitals and any insurance companies, third party administrators or managed care companies. This would include disclosure via facsimile and other secure electronic communication channels.

Patient Signature

Date

Printed Name

Date of Birth