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*ESTABLISHED 1947*

INTERVENTIONAL PAIN MANAGEMENT

KEVIN T. TOLIVER, M.D.

**INITIAL PATIENT QUESTIONNAIRE  
LARRY D. DODGE, M.D.**

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

**Job Description**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Right/Left Handed

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs.

Employer at the time of injury: \_\_\_\_\_

How long have you worked for this employer? \_\_\_\_\_

Job Title: \_\_\_\_\_

Number of hours per day? \_\_\_\_\_ How many days per week? \_\_\_\_\_

Basic work duties at the time of injury: \_\_\_\_\_

Estimate the amount of weight you lift at any one time during your workday: \_\_\_\_\_

Did you work somewhere else at the same time you worked for this employer? \_\_\_\_\_ If yes, what were your duties? \_\_\_\_\_

List places of employment for the last 10 years:

1) Employer \_\_\_\_\_ Position \_\_\_\_\_ How Long? \_\_\_\_\_

2) Employer \_\_\_\_\_ Position \_\_\_\_\_ How Long? \_\_\_\_\_

3) Employer \_\_\_\_\_ Position \_\_\_\_\_ How Long? \_\_\_\_\_

## History of Injury

Specific date of injury: \_\_\_\_\_

If there is no specific date of injury, when did you first begin to have problems? \_\_\_\_\_

Tell in your own words what happened: \_\_\_\_\_

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Did you continue to work? \_\_\_\_\_

When did you report this injury? \_\_\_\_\_ To Whom? \_\_\_\_\_

When did you **first** receive treatment? \_\_\_\_\_

Where did you receive treatment? \_\_\_\_\_

Did you have: \_\_\_ X-rays \_\_\_ Medication \_\_\_ Injections \_\_\_ Therapy

List all physicians seen:

1) Dr. \_\_\_\_\_ Date seen: \_\_\_\_\_

Treatment given: \_\_\_ X-Rays \_\_\_ Medication \_\_\_ MRI \_\_\_ Injections

\_\_\_ Splints \_\_\_ Physical therapy \_\_\_ times per week for \_\_\_ weeks

Did any treatment help? \_\_\_ If yes, what helped? \_\_\_\_\_

What were you told was the problem? \_\_\_\_\_

2) Dr. \_\_\_\_\_ Date seen: \_\_\_\_\_

Treatment given: \_\_\_ X-Rays \_\_\_ Medication \_\_\_ MRI \_\_\_ Injections

\_\_\_ Splints \_\_\_ Physical therapy \_\_\_ times per week for \_\_\_ weeks

Did any treatment help? \_\_\_ If yes, what helped? \_\_\_\_\_

What were you told was the problem? \_\_\_\_\_

Did you return to work? \_\_\_ If yes, when? \_\_\_\_\_

Are you working for the same employer? \_\_\_ Who is your present Employer? \_\_\_\_\_

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What are your new duties? \_\_\_\_\_

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If you did not return to work when were you released, why?

\_\_\_\_\_

List all dates you did **not** work:

From \_\_\_\_\_ To \_\_\_\_\_

List all dates you performed **light** duty:

From \_\_\_\_\_ To \_\_\_\_\_

When did you return to regular duty? \_\_\_\_\_

Since this injury, have you had any other injuries? \_\_\_\_\_

If yes, what body parts were injured? \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Was this work related? \_\_\_\_\_ If yes, describe all treatment and where you received this treatment: \_\_\_\_\_

\_\_\_\_\_

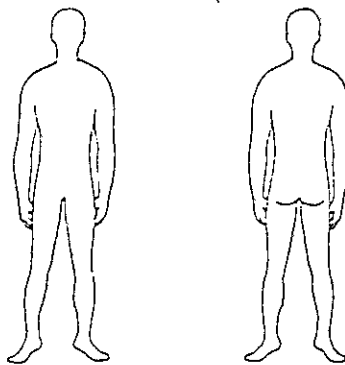
### Present Complaints

Are you presently having pain? \_\_\_\_\_ If yes, list all areas where you are having pain.

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

Please mark on the diagram where your pain is located.



Is the pain present all the time? \_\_\_\_\_

What activities cause pain? \_\_\_\_\_

What relieves your pain? \_\_\_\_\_

Does your pain radiate or travel? \_\_\_\_\_

Do you have numbness? \_\_\_\_\_ ;tingling? \_\_\_\_\_

Do you have swelling? \_\_\_\_\_ ;stiffness? \_\_\_\_\_

If you have a back problem, do you have loss of bowel or bladder control since the injury? \_\_\_\_\_  
\_\_\_\_\_

On a scale of 1-10, with 10 being the worst, what is your pain now? \_\_\_\_\_

### Past Medical History

Have you had any previous work related injuries? \_\_\_\_\_ If yes, describe in detail \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any injuries to the body parts involved in this claim in the past? If yes, were these work related? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did this occur? \_\_\_\_\_ If work related, did you receive a disability rating \_\_\_\_\_ If yes, what was the rating \_\_\_\_\_

### Medical History

Circle any and all conditions listed below that you have received treatment for in the past?

Diabetes Heart murmur High blood pressure Asthma Ulcers

Lung problems Kidney problems Tumors/Cancer Arthritis

List any allergies to medications: \_\_\_\_\_  
\_\_\_\_\_

List previous surgeries and dates: \_\_\_\_\_  
\_\_\_\_\_

List present medications: \_\_\_\_\_  
\_\_\_\_\_

### Family History (If significant to the present injury)

### Social History

Do you smoke? \_\_\_\_\_ How much per day? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink? \_\_\_\_\_ How much per day? \_\_\_\_\_ How long? \_\_\_\_\_

**For Women Only**

Do you think that you might currently be pregnant? \_\_\_\_\_ If yes, when is your estimated date of delivery? \_\_\_\_\_  
\_\_\_\_\_

**A.D.L.**

In order to assess your limitations with activities of daily living please answer the following.

Activity

Sleep Disturbance \_\_\_\_\_ Yes \_\_\_\_\_ No

Travel

a) Riding \_\_\_\_\_ Yes \_\_\_\_\_ No

b) Driving \_\_\_\_\_ Yes \_\_\_\_\_ No

c) Flying \_\_\_\_\_ Yes \_\_\_\_\_ No

Sexual Function

a) Orgasm \_\_\_\_\_ Yes \_\_\_\_\_ No

b) Ejaculation \_\_\_\_\_ Yes \_\_\_\_\_ No

c) Lubrication \_\_\_\_\_ Yes \_\_\_\_\_ No

d) Erection \_\_\_\_\_ Yes \_\_\_\_\_ No

Nonspecialized Hand Activities

a) Grasping \_\_\_\_\_ Yes \_\_\_\_\_ No

b) Lifting \_\_\_\_\_ Yes \_\_\_\_\_ No

Sensory Function

a) Hearing \_\_\_\_\_ Yes \_\_\_\_\_ No

b) Seeing \_\_\_\_\_ Yes \_\_\_\_\_ No

c) Sensation (feeling) \_\_\_\_\_ Yes \_\_\_\_\_ No

d) Tasting \_\_\_\_\_ Yes \_\_\_\_\_ No

e) Smelling \_\_\_\_\_ Yes \_\_\_\_\_ No

Physical Activity

a) Standing \_\_\_\_\_ Yes \_\_\_\_\_ No

b) Sitting \_\_\_\_\_ Yes \_\_\_\_\_ No

c) Reclining \_\_\_\_\_ Yes \_\_\_\_\_ No

d) Walking \_\_\_\_\_ Yes \_\_\_\_\_ No

e) Climbing Stairs \_\_\_\_\_ Yes \_\_\_\_\_ No

Communication

a) Writing \_\_\_\_\_ Yes \_\_\_\_\_ No

b) Typing \_\_\_\_\_ Yes \_\_\_\_\_ No

c) Seeing \_\_\_\_\_ Yes \_\_\_\_\_ No

d) Hearing \_\_\_\_\_ Yes \_\_\_\_\_ No

e) Speaking \_\_\_\_\_ Yes \_\_\_\_\_ No

**Thank you for your time in completing this questionnaire**