

Patient's name _____ Date of birth _____

1. Previous medical history
a) Symptoms first appeared or accident happened on _____
b) Date total disability began _____
c) Has patient already had same or similar condition?
d) Is condition due to injury or sickness arising from patient's employment?
e) If condition is due to pregnancy, what is (or was) the expected date of delivery?
f) If relapse, date total disability reoccurred:
g) Name of other attending physicians

2. Diagnosis of present condition
a) Primary _____
b) Secondary (if applicable) _____
c) Results of current X-rays, E.K.G. or any other special tests _____
d) Describe the conditions that currently prevent the patient from returning to his/her occupation. Are they temporary? permanent?
e) Additional conditions which might affect the duration of disability _____

3. Treatment
a) Date of first visit for present period of disability _____
b) Date of last visit _____
c) Frequency of visits Weekly Monthly Other (specify)
d) Is patient following recommended treatment program? Yes No
e) Nature and duration of treatment _____

4. Hospitalization
a) Name of hospital _____
b) Hospitalized from _____ to _____
c) If surgery performed, describe: _____

5. Physical incapacities
a) Is patient: Ambulatory? House confined? Bedridden? Hospitalized?
b) If ambulatory or house confined, please complete the section below
No restriction; capable of all physical activities
Moderate restriction; normal duties with moderate effort
Marked restriction; light duties
Complete restriction; total incapacity

6. Nervous or psychiatric disorders
a) What are the subjective and objective symptoms observed?
b) What are the psychosocial stressors?
c) Has the patient been referred to a psychiatrist? (If yes, name)

7. Cardiac status (if related to disability)
a) Functional capacity Class 1 (no limitation) Class 2 (slight limitation) Class 3 (marked limitation) Class 4 (complete limitation)
b) Blood pressure (latest visit) _____ Systol./Diastol.

8. Progress
Recovered Improved Not improved Deteriorated Consolidation _____ DAP _____%

9. Prognosis
a) Is patient now totally disabled?
b) If yes, when should patient be able to resume work?
c) If no, when was patient able to resume work?
d) If indefinite, give the estimated number of additional weeks/months before patient's return: Months Weeks Never

10. Rehabilitation
a) Can the patient participate in or benefit from a rehabilitation program? Yes -> Starting _____
b) If not, when and why? _____

Remarks _____

Physician's name (Print) _____ Address _____

Telephone no. _____ Signature _____ Date _____ M.D. _____