Next Generation
Occupational Medicine

DR KAR LOONG NG
MBBS, GDOH&SM, FAFOEM (RACP)
Occupational and Environmental Physician
Provider No. 232384HJ

INDEPENDENT MEDICAL EXAMINATION QUESTIONAIRE

Welcome to Next Generation Occupational Medicine. To make your assessment as efficient and informative as possible we ask you to please fill out the following questions about yourself:

Claim number _____ **Insurer & Contact no** _____

Personal Details

Your Full Name _____ DOB _____ Dominant Hand _____

Your GP_____ Your Specialist(s) _____

Pre-injury Job _____ Hours per week _____

How long were you employed before being injured? _____ Do you have a second job? _____

Education and Personal History

Where were you born? _____ What level of school did you complete?_____

Have you obtained further qualifications? _____ If so, please list them below :

_____

_____

_____

Last 5 job positions

Where and when did you work in your last 5 years? Please include periods of unemployment or study :

Period/Year	Job Title	Employer	Reason For Leaving

Pre-injury Job and Duties

Please describe your pre-injury job, duties and how do you do it _____

_____

_____

Are you currently off work ? _____Are you currently on work restrictions _____ Reduced hours ? _____

If so please explain below (include work restrictions specified by doctor and description of duties):

_____

_____

_____

Medical History

Please describe to the best of your ability, the injury or medical condition(s) that is currently affecting you :

Date and location of injury / illness: _____

_____

Brief description of the event : _____

_____

_____

_____

_____

What problems and symptoms are you currently having :_____

_____

_____

_____

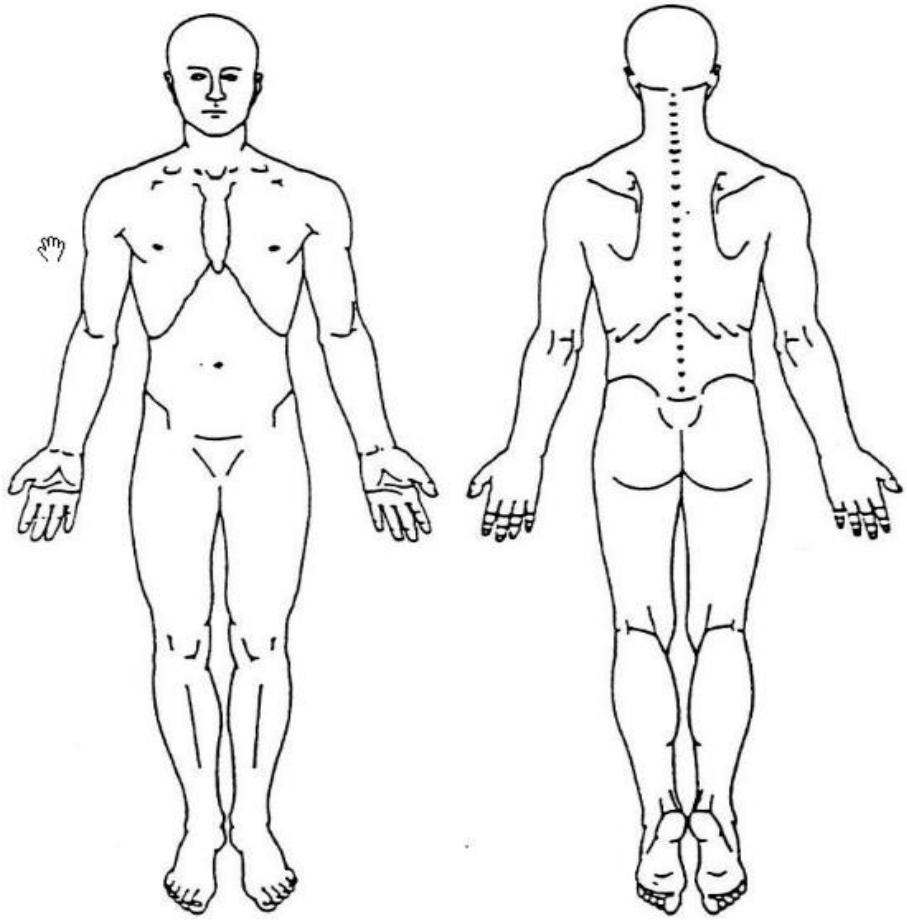
_____

_____

_____

Description of injury or injuries (please use diagram to indicate where you feel pain – please include ALL affected areas)

Please mark on the diagram the site of pain. Also mark your worst pain with an 'x' and mark any numbness with an 'o'



Investigations

Please tick (✓) if you have had the following investigations for current injury and list approximate dates

☐ Xrays _____ ☐ CTscan_____

☐ Bone Scan_____ ☐ MRI _____

☐ Ultrasound _____ ☐ Nerve Studies _____

☐ Blood Tests_____ ☐ Other _____

Current treatment for injury (please tick ✓)

Treatment type			Number of sessions				Helpfulness		
Physiotherapy	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Chiropractic	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Hydrotherapy	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Gym	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Psychology	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Acupuncture	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
TENS	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Massage	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐
Other	Yes ☐	No ☐	1-5 ☐	6-10 ☐	11-20 ☐	>20 ☐	nil ☐	some ☐	very ☐

Medication

Please list **ALL** medication you are **currently** taking (including those for pain) and indicate (tick box) whether or not they are helpful.

			Benefit (tick box)			
Medication	**Dose**	**Side effect**	**none**	**mild**	**moderate**	**marked**

Past Medical History

Condition	Treatment	Status

Psychosocial History

What type of dwelling do you live in? _____ Do you have any dependants? _____

Who else lives with you? _____

What hobbies/interests do you have? _____

Have you had to change or give up any hobbies/ interests as a result of your injury(s) ? If so, please explain :

_____

Are you a smoker?_____ (if so please indicate how much)_____

Do you drink alcohol? _____ (if so please indicate how much)_____

Activities of Daily Living

Are you having any trouble with the following activities of daily living? If so please comment on those difficulties :

Activity	Examples	Comments
Self Care	*Showering, Toilet, Dressing / Grooming*	
Meals	*Preparing eg chop / cut, cooking, feeding/eating, doing dishes*	
Home In	*Wiping down, washing & hanging clothes, vacuum/mop, dusting, taking rubbish out, feeding pets*	
Home Out	*Mowing lawns, weeding, watering, smoke alarms, cleaning car*	
Driving	*Type of car, Manual/Auto, How long or far?*	
Shopping	*Pushing trolleys, lifting bags, picking items from shelves*	
Admin	*Paying bills, using computer, using phone*	
Tolerances		
Sitting	*How long?*	
Standing	*How long in one spot? eg queue, bus stop, checkout*	
Slopes/Stairs	*How many flights, difficulty with ramps?*	
Walking	*How long / far?*	
Lifting	*How heavy can you lift?*	
Bending	*Can you pick objects from the floor?*	
Hold/ Grasp /Dexterity	*Do you have trouble with fine hand movements eg writing, using keys, doing buttons?*	

I consent to Next Generation Occupational Medicine obtaining and sharing information about my medical condition(s) with my treating medical practitioners, radiology and pathology providers, legal representatives, insurance agent, rehabilitation provider and employer, unless otherwise specified.

_____ _____ _____

(PRINT FULL NAME) **(signature)** **(date)**