OSCAR N. ABELIUK, M.D.
NEUROLOGIST

Name_____

Social Security #_____

RE-EVALUATION QUESTIONNAIRE

Please fill out this questionnaire as carefully as you can. **TRY TO ANSWER ALL THE QUESTIONS** that apply to you. The more complete information you supply, the better your doctor will be able to understand your current status and help you.

You may use the back side of any page to explain your answers or to give more information. Some questions are of a personal nature; they are intended only to assist the doctor in assessing your problem.

Who referred you to this office?_____Who is your Internist/Family Physician?_____

Please list the main symptoms for which you were ORIGINALLY referred to this office.

_____

_____

_____

Is this condition is due to a work related accident or personal injury? *YES____* *NO____*

Employer at the time of the injury :

_____

Date hired: _____

Job title when injured: _____

Were you working at any *other* job at the time of your injury?_____

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PRESENT COMPLAINTS

Describe in order, beginning with **what bothers you the most at the present time.** Please explain **in detail.**

(Please use the back of the page if you need more space)

List below any treatments, hospitalizations, medications that you have had in connection with your current problem **since your last visit**. List the names of all the physicians and doctors who have treated you or with whom you have consulted.

How much time (give dates) have you missed from work due to your current problem? Explain.

Were any symptoms noted during prior or subsequent employment? Explain

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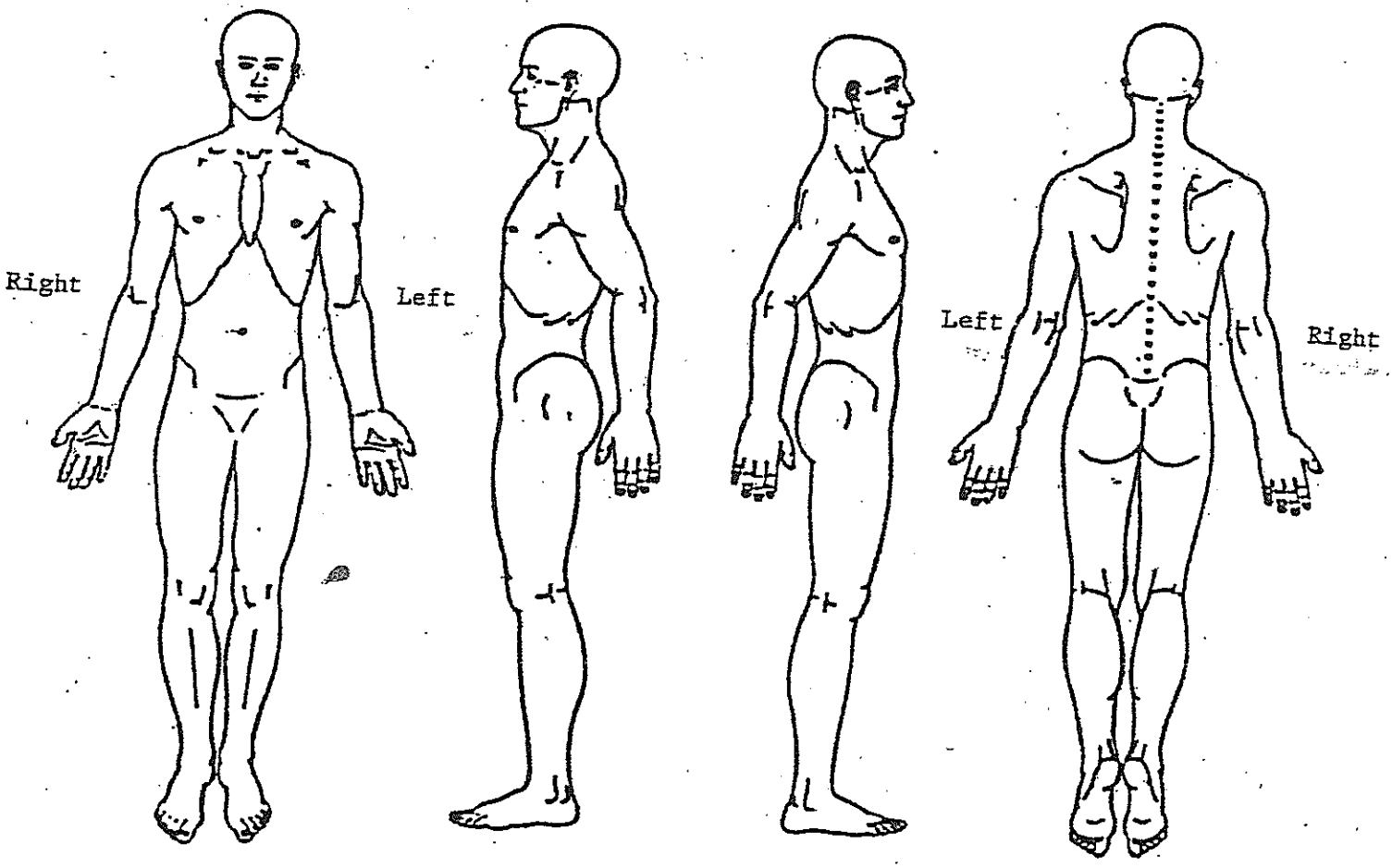
LOCATION OF YOUR PRESENT PAIN

Using these pictures and the ones in the next page, indicate which parts of your body are currently affected by pain by shading them with a pen or pencil.

If you have more than one type of pain, you may use a different color for each.

If you have any spots that are particularly sensitive, painful or tender, or than trigger pain when touched, label them with an "X".



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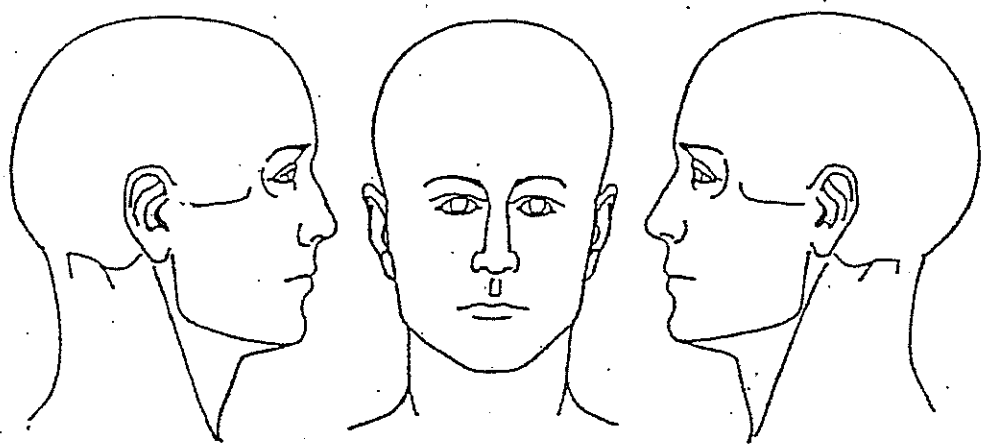
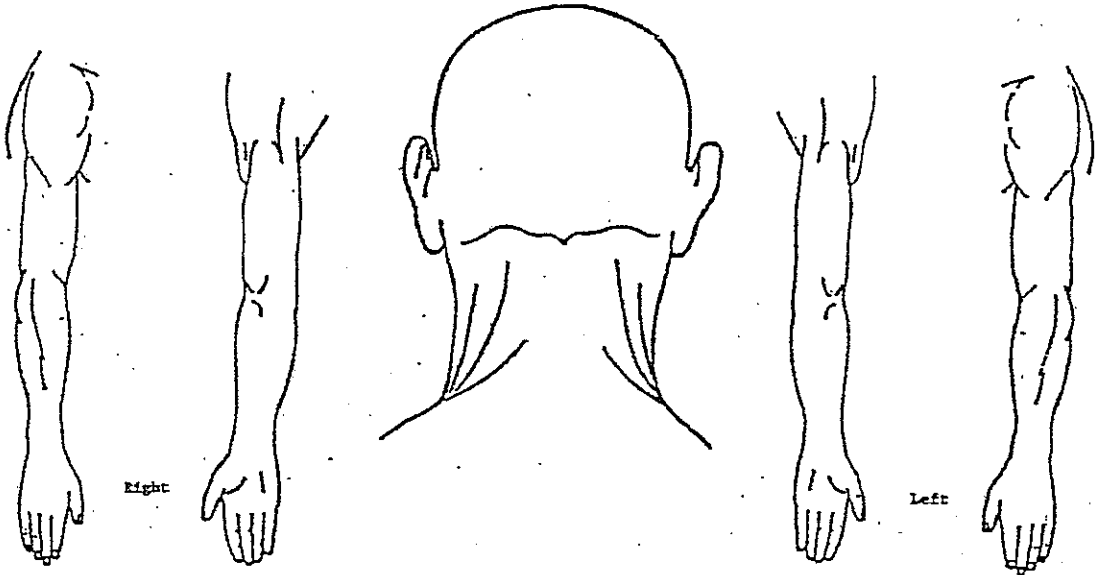
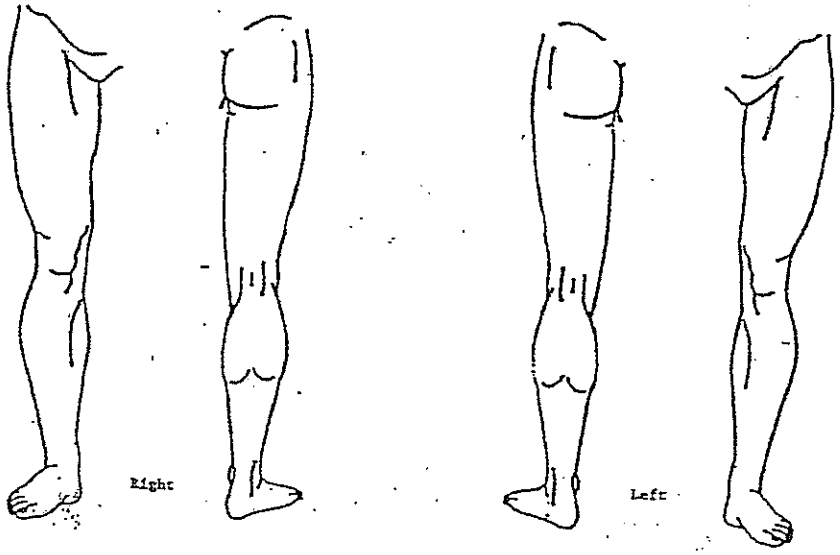
(more pictures)







1/17/00

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Please describe any *other* health problem or injury you have experienced connected with your present or past jobs, since your last visit.

(Please use the back of the page if you need more space)

ON-THE-JOB INJURY (if applicable)

Date you began the job where you were injured?_____Are you still employed there?____

If **NO,** give date you stopped work _____ and indicate the reason below:

Reason: _____disability retirement _____regular retirement ____applied for retirement
_____medical reasons _____quit ____laid off _____new job _____ other

Explain:_____

Did you have a pre-employment physical examination? _____Yes _____No

If **YES**, were work restrictions imposed?_____Yes _____No
Explain_____

Have you **ever** had work restrictions imposed?_____Yes ____No
Explain_____

Please describe your job duties in detail.

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CURRENT PERSONAL INFORMATION

Please indicate any areas of your personal information that may have changed since your last visit.

Married___ Single___ Divorced___ Separated___ Widowed___

Occupation:_____

Height:_____ Weight now: _____ Weight one year ago_____ Maximum weight:_____when_____

Are you pregnant? (Y/N)_____
Do you smoke? (Y/N) ____ How many packs/day?_____

Do you drink (Y/N)_____ Drinks per day___ per week ____

Are you on a special diet? Yes___ No___ Type:_____

NON-WORK ACTIVITIES

Arts/crafts___ Tennis___ Golf___ Skiing___ Bowling___ Fishing___ Hunting___ Camping___
Running___ Hiking___ Travel___ Reading___ Movies___ Auto Repair___ Spectator Sports___
Shopping___ Gardening___ Housework___ TV___

STRESS FACTORS

Job	low___	medium___	high___
Financial	low___	medium___	high___
Personal	low___	medium___	high___
Marital	low___	medium___	high___

MEDICAL HISTORY

Please list any of the following that you have experienced since your last visit. Include minor surgeries.

PAST HOSPITALIZATIONS: **None** ___

APPROX. DATE	REASON	TREATMENT	HOSPITAL/CITY	DOCTOR

ILLNESSES FOR WHICH YOU WERE NOT HOSPITALIZED: **No serious illnesses**_____

APPROX. DATE	ILLNESS

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NON WORK-RELATED ACCIDENTS & INJURIES (INCLUDING AUTO ACCIDENTS)

No recent accidents_____

APPROX. DATE	TYPE OF ACCIDENT	INJURIES

CURRENT MEDICATIONS:

NAME OF MEDICINE	TAKING FOR:	LENGTH OF TIME TAKEN

Are you allergic to any medications? **No known medication allergies____**

NAME OF MEDICINE	TYPE OF REACTION

Previous Tests:

CT of head___ CT of back___ MRI of head___ MRI of neck___ X-Ray of head___ Myelogram___

X-ray of neck___ X-Ray of back___ EEG (brain waves) ___ EMG (nerve test)___ Discogram___

Current physicians *OTHER THAN YOUR INTERNIST OR FAMILY PHYSICIAN:*

NAME OF PHYSICIAN	SPECIALTY	CITY

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OCCUPATIONAL/ENVIRONMENTAL HISTORY

Please fill in the table, listing all jobs at which you have worked, including short-term, seasonal and part-time employment. Start with your present job and go back to your first. Use additional paper if necessary.

WORKPLACE (Employer's name and address or city	Dates Worked From	To	Full time or Part Time?	Type of industry	Were you ever off work for a health problem or injury? If yes, describe