



PROFESSIONAL REHABILITATION & OCCUPATIONAL SERVICES, INC.

Medical Information Sheet

NAME _____

DATE _____

	NAME & CITY	DATE OF LAST VISIT	DATE OF NEXT VISIT
TREATING PHYSICIAN (The one you've seen the most often.)			
OTHER PHYSICIANS YOU'VE SEEN			

What is your injury? _____

Have you had surgery for this injury? Yes No If yes, please fill in the information below:

DOCTOR/SURGEON	DATE	TYPE OF SURGERY

Comments you have about your surgery: _____

Comments your doctors have made concerning your recovery: _____

List names or types of medicines you are taking now and how often:

MEDICINE	REASON	HOW OFTEN TAKEN
1.		
2.		
3.		
4.		
5.		



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EMPLOYEE'S DESCRIPTION OF JOB DUTIES

Please use this form to describe the physical duties and responsibilities of the job you held prior to injury. **Place a check where appropriate.**

JOB TITLE: _____

- A. **LIFTING**
Your most reasonable lifting and/or carrying requirement:
100 lbs. occasionally to 50 lbs. frequently _____
50 lbs occasionally to 25 lbs. frequently _____
20 lbs. occasionally to 10 lbs. frequently _____
Under 10 lbs. _____
No Lifting _____
- B. **CLIMBING - BALANCING**
Climbing _____
Balancing _____
- C. **STOOPING - BENDING**
Stooping/Bending _____
Crouching/Crawling _____
- D. **REACHING - HANDLING**
Reaching (extending arms in all directions) _____
Handling (gross motor manipulation with hands,
including grasping, seizing, holding,
twisting, and turning) _____
Fingering (use of finger for touch, feel, pick,
or dexterity) _____
- E. **TALKING - HEARING - VISION**
Talking _____
Hearing _____
Vision _____
- F. **INSIDE - OUTSIDE**
Neither inside nor outside _____
Inside _____
Outside _____
- G. **COLD - HEAT**
Cold climate (40° F. or less) _____
Hot (100° F. or more) _____

H. **WET - HUMID**
Activity in wet/humid setting _____
Activity in dry setting _____

I. **NOISE**
Very loud noise _____
Moderately loud noise _____
Minimally loud noise _____
Quiet _____

J. **HAZARDS**
Moving machinery _____
Fixed machinery _____
Chemicals _____
Explosives _____
Electrical devices _____
Moving quickly out of harms' way _____
Other _____

K. **FUMES - ODORS**
Fumes _____
Odors _____
Dust _____
Gasses _____
Ventilation _____
Other _____

L. **GENERAL PHYSICAL FUNCTIONING REQUIREMENT OF YOUR JOB:**

1. Stand daily (with break every two hours) for:
___ 8 hrs ___ 6 hrs ___ 4 hrs ___ 2 hrs ___ None

2. Sit daily (with breaks) for:
___ 8 hrs ___ 6 hrs ___ 4 hrs ___ 2 hrs ___ None

3. Stand and sit intermittently with breaks (specify hrs): _____

4. Walk daily:
___ Less than 10 ft. ___ About 500 ft. ___ 1/4 mile

Do you have any suggestions as to how your job could be changed so you could still perform it?

**PROFESSIONAL REHABILITATION AND OCCUPATIONAL SERVICES, INC.
COMPLETE WORK HISTORY FOR THE LAST 15 YEARS**

YOUR NAME: _____

DATE: _____

DATES OF EMPLOYMENT	NAME OF EMPLOYER	FULL OR PART TIME <i>(Please Circle)</i>	SPECIFIC JOB INFORMATION	RATE OF PAY
<i>Begin Date:</i> <i>End Date:</i>		<p align="center">FT</p> <p align="center">PT</p>	<i>Job Title:</i> <i>Job Duties:</i> <i>Reason for Leaving:</i>	<p align="center">\$</p>
<i>Begin Date:</i> <i>End Date:</i>		<p align="center">FT</p> <p align="center">PT</p>	<i>Job Title:</i> <i>Job Duties:</i> <i>Reason for Leaving:</i>	<p align="center">\$</p>
<i>Begin Date:</i> <i>End Date:</i>		<p align="center">FT</p> <p align="center">PT</p>	<i>Job Title:</i> <i>Job Duties:</i> <i>Reason for Leaving:</i>	<p align="center">\$</p>