PROFESSIONAL MEDICAL EVALUATIONS, P.A.

COVID-19 QUESTIONNAIRE

TO BE COMPLETED BY ALL INDEPENDENT MEDICAL EXAMINATION PATIENTS

Please respond by checking any box applicable to you and sign below.
Please provide the completed copy to us ***prior to*** your scheduled examination.

HAVE YOU RECEIVED THE COVID VACCINE? **Yes** _____ **No** _____
If **yes,** which vaccine have you received? _____ Date _____
If **no**, please explain _____

IF YOU HAVE TESTED POSITIVE FOR COVID-19, which of the following statements are true, if any:

☐ **If you were symptomatic** (had symptoms), you have been in isolation for at least 14 days since symptoms first began, and you have not had symptoms in the past 3 days.

☐ **If you were asymptomatic** (did not have symptoms), you have been in isolation for at least 14 days beginning from the date you were tested and you have not experienced any symptoms during this 14-day period.

☐ **You have NOT completed a 14-day quarantine.** If you check this box, please note the date you were diagnosed with COVID-19 and the date you first became symptomatic (if applicable).
Date first symptomatic ___/___/___ Date diagnosed with COVID-19 ___/___/___

☐ **If you have tested positive, have you been re-tested and if so, date and results?** _____

_____

IF YOU HAVE NOT TESTED POSITIVE FOR COVID-19, please select any of the following that apply:

☐ **Have you travelled** internationally in the past 14 days? If so, note date of your return and area(s) you visited.
Date of return from international travel ___/___/___ Areas visited: _____

☐ **Have you had close contact (closer than 6 feet for 10 minutes or more) with someone** diagnosed with or suspected to have COVID-10 within the past 14 days? (For ex., a family member you live with, or a co-worker)? If so, please note the last date you had contact with this person and whether this person was actually diagnosed.
Date of last contact ___/___/___ Person actually diagnosed? ___Yes ___No

☐ **Have you been mandated to go unto quarantine** by your physician or Dept. of Health within the past 14 days? If so, please explain the date the quarantine began and reason for quarantine.
Date quarantine began ___/___/___ Reason for quarantine _____

☐ **Have you had fever, chills, cough, shortness of breath, sore throat, or any other flu-like symptoms** within the past 14 days? If so, date you first had symptoms and the last date you had symptoms.
Date first symptomatic ___/___/___ Date last symptomatic ___/___/___

Name (Print): _____ **Signature:** _____ **Date:** ___/___/___

PROFESSIONAL MEDICAL EVALUATIONS, P.A.

Board Certified Orthopedic Surgeons

STANDARD I.M.E. FORM

You have presented for a third-party evaluation. In order to assess your injury, please fill out this form completely.

Name_____ Date_____

Address_____ City_____ State____ Zip_____

Date of Birth_____ Age_____ Social Security # xxx-xx-___ ___ ___ ___

Home Phone No. (_____)_____ Work Phone No. (_____)_____

Emergency Contact Name/Phone _____

Height _____ Hair Color _____

Weight _____ Eye Color _____

Distinguishing Marks, if any_____

Date of Accident_____ What did you hurt and how? _____

_____

Did you go to the hospital after the injury?	____Yes	____No If yes, when?_____
If yes, were you admitted?	____Yes	____No
Were you taken by ambulance?	____Yes	____No
Are you currently undergoing treatment?	____Yes	____No If yes, how often?_____
Were x-rays taken?	____Yes	____No
If Yes, Did you bring them with you?	____Yes	____No
Were MRI's performed?	____Yes	____No
If Yes, Did you bring them with you?	____Yes	____No
Have you had any previous accidents?	____Yes	____No If yes, when?_____
Have you had any previous injuries?	____Yes	____No If yes, when?_____

Under these circumstances, the physician will evaluate your history and present condition. As such, there is no representation of a physician/patient relationship. This means that there will be no discussion regarding diagnosis, nor recommendations for treatment. There is no patient confidentiality in a third-party evaluation. The sole purpose of this examination is for the use of the party ordering the examination.

I understand and consent:_____ Date:_____

Witness _____

Signature

PROFESSIONAL MEDICAL EVALUATIONS, P.A.

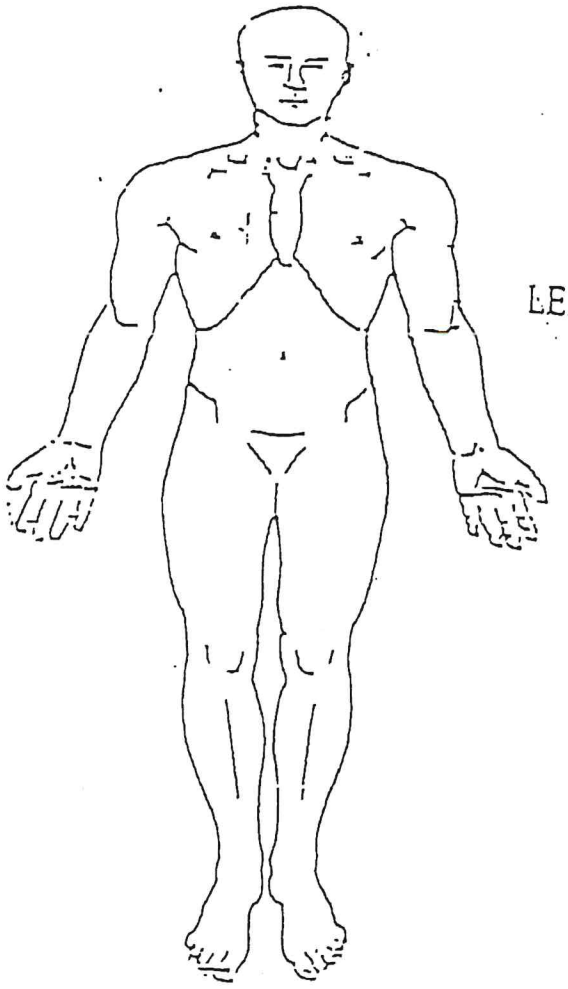
PAIN DRAWING

Your Name _____ Date_____

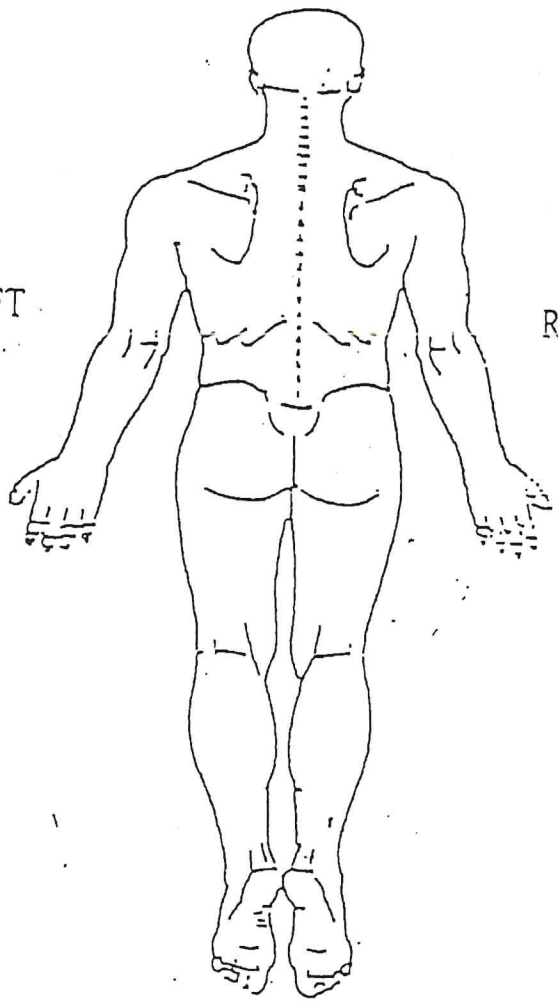
Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
◊ ◊ ◊	= = =	O O O	X X X	/ / /	• • •

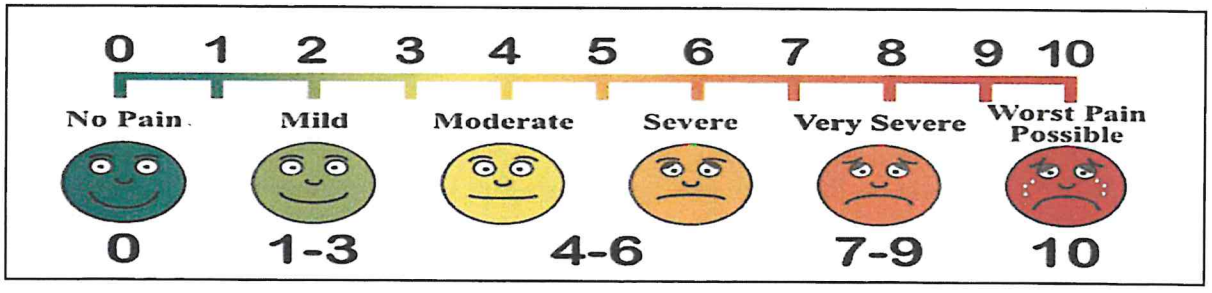
RIGHT



LEFT



RIGHT



Signature of Patient_____

PHOTOGRAPH AUTHORIZATION

I, _____, authorized the staff of Professional Medication Evaluations, P.A. to take a facial photograph for the purpose of proper identification in regards to the Independent Medical Evaluation for which I was sent and for my medical record.

In addition, and if necessary, I authorize the staff of Professional Medical Evaluations, P.A. to photograph the areas of injury that were sustained in my accident.

_____
Signature of Patient

_____
Date of Examination

_____
Signature of Witness