

Medical questionnaire TO BE FILLED IN BEFORE Medico-legal examination with Mr KURUP (Consultant Orthopaedic Surgeon)

Dear

I have been asked to prepare an independent medical report on you by

Your appointment has been made onat

**Venue: Bostonian Private Wing PE21 9QS / Johnson Hospital PE11 3DT
Boston West Hospital PE21 8EG/ Fitzwilliam Hospital PE3 9AQ**

1. For me to do this, you will need to tell me details about your accident. I will need to examine you. It is vital that you do not underestimate the effect the accident had on you and equally important that you do not exaggerate the effect that the accident had on you.

2. When preparing a report, I have access to all your previous medical records if you have authorised release of the same through your Solicitor including past illnesses, accidents, injuries, operations and medications and these details will be included in your report.

3. During the examination, I will ask you to perform certain movements; however, you must stop me if you feel any increase in pain. I will prepare a report based on what you tell me, and what I find during the examination. It is not possible to add to the report any symptoms that you do not tell me or write in the questionnaire at a later date.

4. I do not represent you - this is your solicitor's job. I AM NOT ON ANY SIDE.
I AM HERE TO ASSESS YOU AND HELP THE COURT TAKE A DECISION.

5. **We do not have a chaperone during the appointment. If you need one to be present at your appointment, please inform us beforehand or bring someone with you.**

Please sign below to indicate that you have read and understood the above.

- 1. I consent to the Medical Expert collecting and sharing my personal data (including my contact details, medical information and any other details relevant to the above-referenced matter) and sharing it with the instructing agency & solicitor.**
- 2. I understand that I may withdraw my consent to the sharing of my personal information (for the purposes of relevant Data Protection legislation) at any time by providing a written request to the Medical Expert.**

Signature of Claimant

Print NameDate

PLEASE REMEMBER TO BRING A PHOTO ID WITH YOU WHEN YOU COME FOR THE INTERVIEW AND EXAMINATION.

Please bring this with you to the appointment, Do NOT post this back to us. If you wish to use an electronic version please email us or download from www.bostonfoot.co.uk

Contact details for Secretary : Mrs. Julie Thornalley
Email : Julie.Thornalley@bostonfoot.co.uk
Phone : 07784374824 Fax: 01205 352849

1. Your full name.....

Date of birth..... Age

Your address.....

.....Post Code.....

PhoneEmail.....

2. Date of injury..... Time.....

3. If your injury was a **Road Traffic Accident (any vehicle)**, Please state

4. The Cityand street.....

5. Were you – Driver / Front seat passenger / Back seat passenger?

6. Make/ Model of your vehicle

7. What damage did the vehicle have? Written off / repaired.....

8. If you were on a **car**

9. Was your seat belt fastened? **YES / NO If not why ?**

10. Did your car have Airbags? **YES / NO** If Yes did they deploy **YES / NO**

11. If you were on a **motorbike or pushbike**

Did you have a helmet on? **Yes / No**

Did you have full protective gear? **Yes / No**

12. If it was an **accident at work place or a public / private facility**

Name of workplaceTown.....

Nature of businessYour job.....

13. Please describe in a few words how the injury / accident happened

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14. What did you do after the accident / injury? [Getting out of car , calling police etc.]

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15. When & where did you first seek medical advice following the injury / accident?

Same day / Next day / Within a week / month / I did not seek medical advice

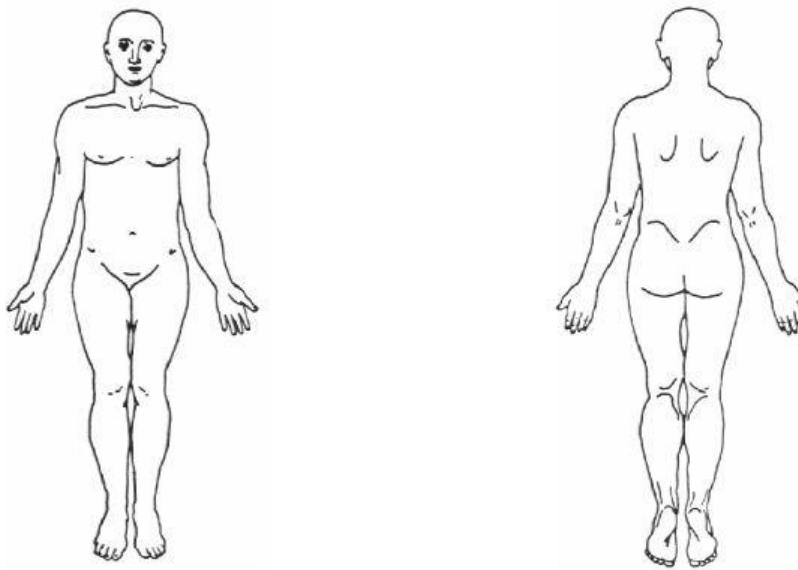
Name GP / Hospital

Please give details of the treatment provided

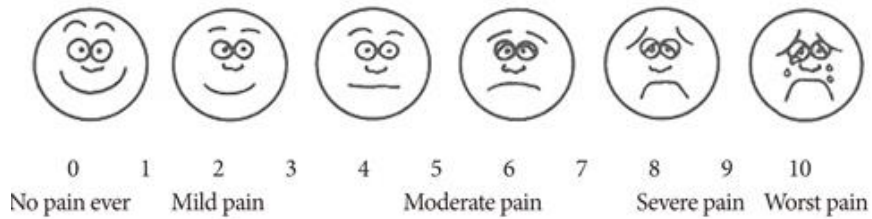
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16. SYMPTOMS / COMPLAINTS

Please mark on the diagram the areas where you have / had pain or other symptoms from the accident?



The scale below is to help you choose severity of symptom, for pain No pain is 0, worst possible pain is 10 (***Pain score of 10 is pain similar to childbirth /labour pains***)



Complaint /Injury/ Symptom eg Pain in foot, Swelling in knee, neck pain etc. For each complaint use a separate row	When did it start?	Do you still have it? If not when did it resolve?	On a scale of 0 to 10 how bad was it when it STARTED.	On a scale of 0 to 10 how bad is it NOW.

17. Have you continued to consult your GP or a hospital doctor following the injury / accident for complaints arising from the injury / accident? **YES / NO**

If YES, please mention the dates and treatment

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18. Have you consulted any therapist (like a physiotherapist / osteopath / chiropractor) following the injury / accident for complaints arising from the injury / accident **YES / NO**

What was the therapy?.....
Name of therapist / clinic
Who arranged it ? Insurance company / GP / Paid by yourself
How many sessions ?.....
Still having physiotherapy?
Details of treatment
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.....

19. Are you taking any medication now for symptoms from the above injury? **YES / NO**.
Please list them here

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20. Your Dominant arm **Right / Left / Ambidextrous**

21. Occupation at the time of accident.....& now.....

22. Do you smoke? **YES / NO** If yes how many cigarettes in a day?.....

23. Do you suffer from any medical conditions like **Diabetes / Hypertension/ Heart problems** ? If yes, please give details

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24. Any previous road traffic accidents or injuries ? **YES / NO**.
Have you had any compensation claims prior to the present accident / injury **YES / NO**.
If yes please give dates and details

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25. Any previous complaints to the areas affected by the accident ? **YES / NO**.
If yes, please give details

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26. Did you suffer from any psychological symptoms from the accident?
 eg : nightmares / flashbacks / fear of travel / anxiety / depression

.....

28. Have you had any sick leave because of this accident. If yes Please give details.

From.....To.....

.....

29. Did you drive away from the accident? (For RTA drivers only) **YES / NO.**

When did you start driving again after the injury?.....

30. PLEASE ENLIST THE ACTIVITIES THAT WERE / ARE DIFFICULT FOR YOU FOLLOWING THE INJURY /ACCIDENT.

Tasks		For how long	Is it fine now?
Self-care	Dressing		
	Bathing / Showering		
	Toileting		
House work	Washing / Ironing		
	Cooking		
	Hoovering		
	Shopping		
Using stairs			
Childcare			
Pet care			
Sex-life			
Gardening			
Working on computer			
DIY			
Anything else?			
Who helped you? Husband/ Wife/ Partner / parents / children / friends . Did you have to pay anyone?			

31. What were your leisure pursuits prior to the accident / injury? (Sports /gym/hobbies)
 Have you been able to restart any of these after the accident / injury?

Leisure interest	When did you restart?	Is it fine now?

32. Was your sleep disturbed? **YES / NO.** For how long ?

If YES, how frequently is it disturbed? 2- 3 nights a week / Once a night / 2-3 times a night
 Why do you think your sleep is disturbed

33. What is your height?Ftin.....cms

34. What is your weight?St.....lbs.....kgs

