

MEDICAL QUESTIONNAIRE TO BE FILLED IN BY CLAIMANTS OF PERSONAL INJURY

Mr. George Ampat

Consultant Orthopaedic & Spinal Surgeon

PATIENT INFORMATION

Dear Sir / Madam

1. I have been asked to prepare an independent medical assessment by Solicitor / Insurance Company / Medical Reporting Agency . To enable me to do this, you will need to tell me about your accident and I will need to examine you. It is important that you tell me about your accident and the result of that accident. 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 / Insurance company agent. These previous medical records would include your past illnesses, accidents, injuries, operations and medications.
3. During the examination, I will ask you to perform certain movements and it is vital that you do this to your best effort. However, you must stop me if you feel any increase in pain. You do not have to suffer any pain or discomfort during these tests. 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.
4. At the end of the examination, I may take photographs. These photographs are to identify you on the report and sometimes to demonstrate the range of motion or other relevant clinical information. Please note that some of these photographs will be included in the report.
5. The report may also contain relevant information from previous medical records maintained by your General Practitioner and / or Hospital.
6. I sometimes record the video / audio of the entire / part of the interview / examination on magnetic / electronic media. The video / audio quality is not very good and the recording is done only to aid me write the report without errors. I assure you that the recording will be maintained confidentially like all other medical records and is only going to be used for purposes of preparing this report and for any enquires that may arise.
7. 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.
8. On the next few pages you will find a questionnaire. It is very vital that you take time and effort to fill in the questionnaire. I require all the information to prepare a proper report and hence request you to answer ALL the questions. If you wish to add any further details to any question please continue on an extra sheet by writing the question number and then providing the extra details. On an average, it takes less than an hour to answer the questionnaire. If you agree, the answers provided by you will be used for research and audit. For purposes of research all the data is clubbed together and no individual patient can be identified.
9. When you come for the appointment please bring a photo ID and all the documents relevant to your injury. If you have maintained a diary with dates please also do bring that along. I thank you for your co-operation.

Signed - George Ampat

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

1. I have read the above information and understand its contents.
2. I consent for photographs to be taken for purposes of this report. (Please delete if required)
3. I consent for the interview to be video / audio taped. (Please delete if required).
4. I authorise Mr. Ampat and his secretary to release information to the requestor of the report. (Please delete if required)
5. I authorise Mr. Ampat to use data collected for purposes of research as long as all personal details are completely anonymised (Please delete if required)

Signature of Patient

Print NameDate

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

NOW PLEASE ANSWER THE QUESTIONS PROVIDED BELOW

- 1. Your full name.....Date of birth.....
- 2. Your address.....Post Code.....
- 3. Name of General Practitioner.....
- 4. Name of surgery.....
- 5. Date of injury..... Time of injury.....
- 6. Please describe in a few words how the injury / accident happened
- 7. Please draw a simple sketch to illustrate how the injury / accident happened

If your injury was a Road Traffic Accident Please state

- 8. The City and street where crash occurred
- 9. What parts of your vehicle were damaged?.....
- 10. What was the approximate cost of repair ?
- 11. Was your seat belt fastened **YES / NO**
- 12. Did your car have Airbags? **YES / NO** If Yes did they deploy **YES / NO**
- 13. Did you get out of the car and exchange details with the other driver **YES / NO**
- 14. When did you first seek medical advice following the injury / accident (Circle one only)
Same day / Next day / Within a week / Within a month / Within 6 months / I did not seek medical advice
- 15. Where did you first seek medical advice following the injury / accident
Accident and Emergency / Walk-in-Centre / General Practitioner
Name GP / Hospital
- Please give details of any X-rays or scans that were taken and the treatment provided
- 16. Have you continued to consult your GP following the injury / accident for complaints arising from the injury / accident **YES / NO**
If YES, how many times? and please mention the dates and treatment.....

17. Have you consulted a hospital doctor following the injury / accident for complaints arising from the injury / accident **YES / NO**

If YES, how many times? and please mention the dates and treatment.....

.....

Name of hospital doctorand speciality (eg.Orthopaedics).....

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

If YES, how many times? and please mention the dates.....

What was the therapy?.....Name of therapist / clinic

19. Have you been unable to work since injury / accident ?

YES COMPLETELY OFF WORK / HAD TO WORK PART TIME /

I DID NOT HAVE TO TAKE ANY TIME OFF WORK

Please provide dates of sick leave. From.....To.....

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

20. Do you normally drive a car? **YES / NO.**

Have you been unable to drive since injury / accident ? **YES / NO.**

If yes, for how long?.....

21. Please describe in a few words your progress following the injury / accident

.....

.....

22. How long following the injury / accident did you take to come back to normal activity (Circle one only)

1 day / 2-3 days / 1 week / 1 month / 2 months / 3 months / 6 months /

1 year / 2 years / I am still not able to perform normal activity

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

For ease I have enumerated some of the activities eg. Dressing, Washing, Bathing / Showering, Toileting, Going up and down stairs, Shopping, Cooking, Washing / Ironing, Dusting, Hoovering, Childcare, Driving, Sex-life, Gardening, Pet care, Working on the computer, Gym work, Sports and DIY. If none leave blank.

At HOME following the injury / accident.
Are they still difficult YES / NO. If yes please give details.

At **WORK** following the injury / accident.

Are they still difficult **YES / NO**. If yes please give details.

At **LEISURE ACTIVITIES** following the injury / accident.

Are they still difficult **YES / NO**. If yes please give details.

24. CURRENT SYMPTOMS / COMPLAINTS IF ANY Please enlist your present / current complaints / problems due to the injury / accident in decreasing order of severity eg Pain in foot, Swelling in knee, neck pain etc. For each complaint use a separate row. **If you have no complaints please leave blank.**

Complaint / Symptom	When did it start?	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 .	What makes the pain worse or brings on the complaint.	What makes the pain better or provides relief.

25. Have you ever in the past (before the accident) had any of the complaints listed above? **YES / NO** .

If YES please provide details.....

PAST MEDICAL HISTORY

26. Any previous accidents or injuries ? **YES / NO.**

If yes please give dates and details.....
.....

27. Any previous illnesses or hospitalisations **YES / NO.**

If yes, please give details.....
.....

28. Have you had any compensation claims prior to the present accident / injury **YES / NO.**

If yes please give details
.....

29. What were your leisure pursuits prior to the present accident? (If none leave blank).....

DRUG HISTORY

30. Do you regularly take any medication **YES / NO.**

31. If yes, please give details.....
.....

32. Have you taken these medications prior to the accident **YES / NO.**

33. If yes, please give details.....

SOCIAL HISTORY

34. Occupation

35. Marital status **Single / Married / Divorced / Other** (please specify).....

36. Children **YES / NO** .If yes numberand ages.....

37. Are you in receipt of Disability / Incapacity living allowance **YES/NO.**

If 'yes', since when?

38. Dominant arm **Right / Left / Ambidextrous**

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

40. Do you drink? **YES / NO** If yes how many units a week.....(A pint of lager is equal to 2 units)

PERSONAL HISTORY

41. Is your sleep disturbed? **YES / NO.**

42. If YES, how frequently is it disturbed Once a week / 2- 3 nights a week / Once a night / 2-3 times a night

43. Why do you think your sleep is disturbed

44. What is your height?.....(in centimeters if possible)

45. What is your weight?.....(in kilograms if possible)

46. In the last 6 months has your weight **Increased / Decreased / Remained constant.**

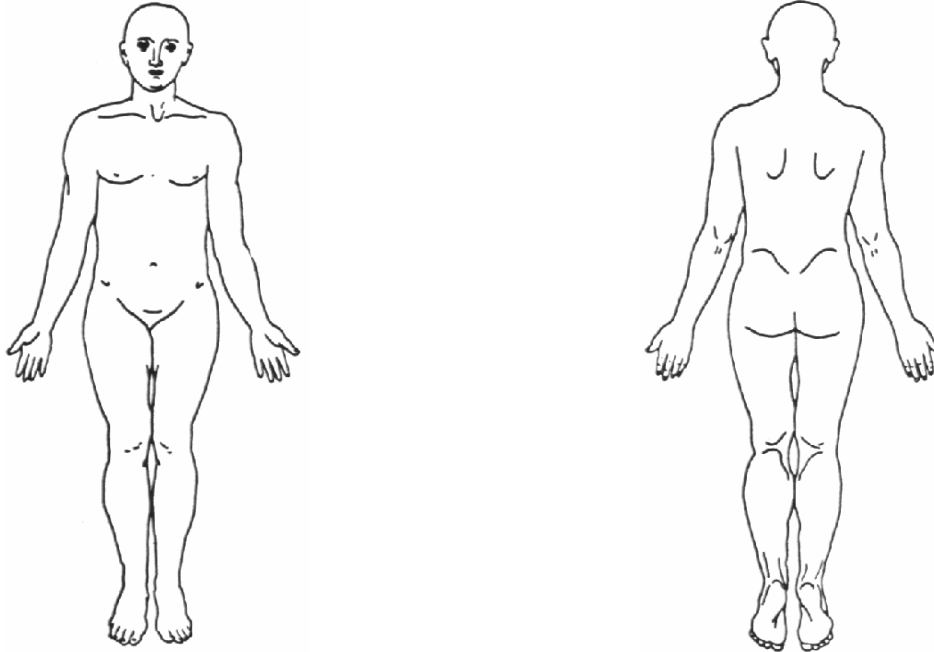
47. Do you have good control of your water works (bladder)? **YES / NO.**

48. Do you have good control of your bowels? **YES / NO.**

49. Do you open your bowels regularly? **YES / NO**

50. Can you climb a flight of stairs without being breathless **YES / NO**. If **NO** why?.....

51. Please mark on the accompanying diagrams the areas that were damaged following the accident / injury. Please also label each mark made by you (e.g. pain, spasm, cut, abrasion, fracture, dislocation etc.)?



52. NUMERICAL RATING SCALE

Below find a few lines marked from “0” to “10”. These lines are to measure the severity of your overall pain. The beginning of the line on the left indicates “0” = ‘NO PAIN’. The end of the line on the right or ‘10’ indicates the most severe pain that you can imagine. Please indicate a value of your pain by drawing a cross (X) on the line.

Immediately after the accident
☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
24 hours after the accident
☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
One month after the accident
☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Now
☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

53. PLEASE USE THIS SPACE TO ENTER ANY OTHER RELEVANT INFORMATION. PLEASE USE A SEPARATE SHEET IF REQUIRED.

A large, empty rectangular box with a thin black border, occupying most of the page. It is intended for the respondent to provide any other relevant information not covered by the questionnaire.

Many thanks for answering the questionnaire. Please bring this along with all other relevant documents for the appointment

Address and locations of clinic

Southport / Ormskirk

Renacres Hall Hospital. Renacres Lane,
Halsall, Lancashire L39 8SE



Liverpool

Eighty Eight Rodney Street,
88 Rodney Street, Liverpool L1 9AR



Manchester

SAYBAT 11 St John Street
Manchester M3 4DW



London

Ten Harley Street, 10 Harley Street,
London W1G 9PF



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