Opened 9-22-15

Khosrow Tabaddor, M.D.

ORTHOPAEDIC SURGEON

8/26/2015

RE: Claim # VE0700184

Tiffany Anderson
2 N. Avena Ave.
Lodi, CA 95240

ATTENTION:
QUESTIONAIRE MUST BE COMPLETED BEFORE APPOINTMENT

Dear Ms.Anderson:

This is a reminder letter of your upcoming appointment for a Qualified Medical Evaluation.

DATE:	**Monday, September 21, 2015**
TIME:	**4:00:00 PM**
LOCATION:	**333 San Carlos Way, Ste. B**
	Stockton, CA95207
TELEPHONE:	**(559) 222-2294**

Enclosed you will find a map to my office plus a questionnaire that I ask you to please fill out immediately and bring to the appointment completed. Please bring any X-Rays, MRI films, or CT scans recently done. If you have additional records or films not served on the QME, please mail them to the carrier so that all parties can be copied before the QME views them. Your appointment will last about one to two hours.

If for any reason you are going to be late or unable to make this appointment, please contact our office immediately. Due to limited space in our waiting room, we request that you bring no more than one person with you to your appointment.

Please call Angie at (559) 492-5602 in our office to confirm that you have received our letter. We look forward to seeing you at your appointment!

Please make copies of your questionnaires before your appointment. Copies can not be made at the office.

Sincerely,

Khosrow Tabaddor, M.D.
ORTHOPAEDIC SURGEON

cc: AIMS P.O. Box 269120 Sacramento, CA 95826-9120 Nancy Urton, Claims Examiner
L/O Stockwell, Harris, Woolverton & Muehl 1545 River Park Dr., Suite 330 Sacramento, CA 95815-

KHOSROW TABADDOR, M.D.
ORTHOPEDIC SURGERY
EXAMINEE QUESTIONNAIRE

Date of Examination _____ Office Location_____

Name _____ DOB _____ Age _____ Soc. Sec. # _____
Address _____ Telephone Number ( ) _____

Height ___ ft. ___ in. φ Right-handed ι Left-handed
Weight ___ lbs.

Interpreter [] yes [] no

Name and Place of Employment at the time of Injury:

What was the date you began working with this company: _____

When did you last work? _____

Previous Occupation: _____

Date(s) of injury: _____

No. Hour per Day: _____ Days per Week: _____

General Job Description/Occupation at the time of Injury:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Activity	Frequency			Number of Hours A Day.							
		Continuous	Intermittent	0	1	2	3	4	5	6	More than 8 hours
A. Sitting											
B. Walking											
C. Standing											
D. Bending											
E. Squatting											
F. Climbing											
G. Kneeling											
H. Twisting											

2 a. Hand Manipulation Required?	NO YES (Check b, c, d) Left YES NO							
2 b. Simple Grasping?	Right	Yes	No		Left	Yes	No	
2 C. Power Grasping?	Right	Yes	No		Left	Yes	No	
2 d. Pushing and pulling?	Right	Yes	No		Left	Yes	No	
2 e. fine Manipulation:	Right	Yes	No		Left	Yes	No	

3. (a) Does the job require working to reach or work above the shoulders?	Yes	No	Frequency
3 (b) Reaching above or below shoulder level?	Yes	No	Frequency

4.Does the job require use of his/her feet to operate foot controls or for repetitive movements	Yes	No
5. Are there Special visual or auditory requirements.	Yes	No

LIFTING FEQUENCY CARRYING FREQUENCY

A. 10 LBS OR LESS
B. 11 TO 25 LBS
C. 26 TO 50 LBS
D. 51 TO 75 LBS
E. 76 TO 100 LBS
F. OVER 100 LBS

Longest Distance Carries: _____

Heaviest item carried and how far? _____

			Description
7. Driving Cars, Trucks, Forklifts or other moving equipment:	YES	NO	_____
8. Working near hazardous equipment and machinery:	YES	NO	_____
9. Walking on uneven grounds:	YES	NO	_____
10. Exposure to dust, gas, or fumes:	YES	NO	_____
11. Exposure to noise:	YES	NO	_____
12. Exposure to extremes in temperature or humidity:	YES	NO	_____
13. Work at Heights:	YES	NO	_____

HISTORY OF INJURY

In your own words, please describe the injury and include…What were you doing? How did it occur? What part of your body was hurt? (Use other side if necessary)

_____

_____

_____

_____

_____

Did you report the injury? _____ If so, to whom? _____ When? _____

Describe your medical treatment:
(Where, when, by whom, what type. Where were you seen first? What treatment did you receive? Were you referred elsewhere?)

_____

_____

_____

Were you able to continue working? _____ If yes, ι modified or ι regular. Were you later taken off work? _____ If so, when and by whom? _____

_____

_____

Were x-rays or other special studies done? ε yes ι no

SPECIAL STUDIES	Body Part	Date Performed	Location Performed	Result
EMG, NCV				
CT Scan				
MRI				
Bone Scan				
Myelogram				
Arthrogram				
Other				

Did you receive physical therapy? o yes o no If yes, for how long? _____
How often? _____

Did this treatment help? ε yes ε no
Explain: _____

_____

_____

Did you have surgery? ε yes ε no
If yes, when? _____

_____

_____

Are you still receiving treatment? o yes ι no
If yes, what type? _____

Please list the names and dates from the first doctor you saw to the present:

Name	Specialty	City	Referred By	Exam Date

With the treatment provided to date, do you feel your condition is: ι Fully recovered θ Improved
ω No change ε Worse

Have you missed any time from work because of the injury? ι yes ε no
If yes, what was your first day of lost time? _____
If yes, when did you return to work? _____
Were you ever told to return to modified work? ι yes ε no
If yes, did you return to work? ι yes ε no When? _____
Is modified work available? ι yes ε no
When do you expect to return to your regular work? _____

Are you currently receiving disability as a result of the work injury in question? ε yes ε no
If yes, from whom? ε Workers' compensation insurance carrier
ε State disability insurance fund
For how long? _____ years _____ months

Have you been recommended for, or have you participated in, a vocational rehabilitation program as a result of this injury? ε yes ε no

CURRENT MEDICAL TREATMENT

Are you still seeing a doctor at this time? ι yes ε no If yes, date last seen: _____
Next appointment _____ Doctor's name _____ E MD O DC

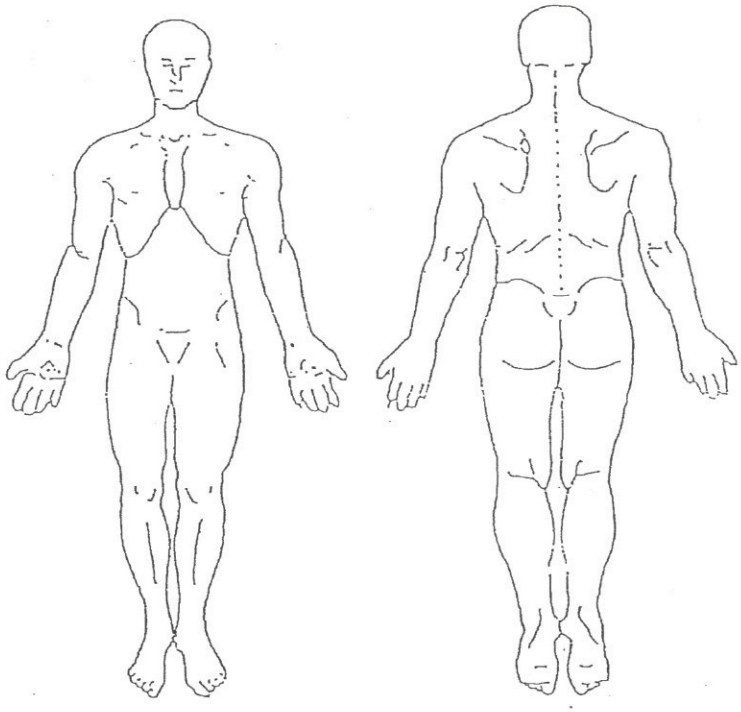
Are you taking any medications? ε yes ε no
If yes, name of medications: _____
How often do you take them? _____
Does the medication help you? _____

Are you receiving physical therapy? ι yes ε no
Is physical therapy helping? _____

PRESENT COMPLAINTS

Indicate, with the following symbols, the kind of pain and where it is located:

Sharp pain = XXXXX
Dull pain = OOOOO
Numbness & Tingling = /////////



What makes it feel better? _____

_____

If you were having previous problems with the same body part involved in this claim, using the scales below, please circle the number that best estimates the amount of pain you were/are having.

Before the work injury: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Your pain now: no pain ←----------→ worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Does your present pain travel to other parts of the body? _____ If yes, where? _____

_____

Is there any stiffness? ε yes ε no If yes, where? _____

Is there any numbness? ε yes ε no If yes, where? _____

Is there any tingling? ε yes ε no If yes, where? _____

Is there any weakness? ε yes ε no If yes, where? _____

Is there any swelling? ε yes ε no If yes, where? _____

Any grinding of the joints? ε yes ε no If yes, where? _____

Any locking of the joints? ε yes ε no If yes, where? _____

Any giving way of joints? ε yes ε no If yes, where? _____

How long can you *sit*: _____ *stand*: _____ *walk*:

Do you use any assistive device(s)? (cane, support, corset, etc.) _____

_____

What can't you do now that you could do before? _____

_____

Are you able to work at the present time? ε yes ε no
If you can, at what? _____

_____

If not, why not? _____

_____

How much can you lift now, and by what method? _____

How much could you lift before? _____

PAST MEDICAL HISTORY

Prior to the injury in question, have you ever had similar problems with, or injuries to, the body part or parts involved in this claim? ε yes ε no
If yes, please give details (IMPORTANT: Were you having problems at the time of the injury? Give dates, doctors, etc.) : _____

Have you had any work or non-work injuries since the injury involved in this claim? ε yes ε no
If yes, please explain: _____

Have you ever had any other work-related injuries? ε yes ε no If yes, please explain _____

Have you ever been involved in any motor vehicle accidents? ε yes ε no If yes, please describe:

Have you had any other serious accidents, sports injuries, or illnesses? ε yes ε no If yes, please describe: _____

Did you ever receive a permanent disability settlement? ε yes ε no
If yes, when? _____

Do you have any medical problems or serious illnesses you are being treated for? _____

Have you had any surgeries? If so, please describe: _____

Do you have any allergies ε yes ε no If yes, list: _____

Check below if you have had any of the following diseases/illnesses as a child or as an adult:

		Diabetes		Kidney Disease		Epilepsy/Seizures	
Anemia		Pneumonia		Fracture		Hepatitis/Jaundice	
Hernia		Chicken Pox		Tuberculosis		High Blood Pressure	
Cancer		Skin Problems		Rheumatic Fever		Gallbladder	
Polio		Stool Disorders		Thyroid Disorder		Bleeding Disorder	
Ulcer		Mental Disorder		Arthritis		Asthma	
Sexually Transmitted Disease				Heart Disease		Other	

Do you have a personal family doctor or chiropractor? ε yes ε no
If yes, name: _____
Date last seen: _____ For what? _____

EXAMINEE PROFILE

Marital Status: ε Married ε Single ε Separated ε Divorced ε Widowed

Number of children _____

Years of education completed: _____ College Degree(s) _____
Special Training _____

Do you smoke cigarettes? ε yes ε no If yes, how much? _____
Do you drink alcoholic beverages? ε yes ε no If yes, how often? _____

Do you have any history of drug or alcohol habit/dependency/or abuse? ε yes ε no
Comment: _____
_____

Do you have any hobbies, special skills, or interests? ε yes ε no If yes, describe: _____
_____
_____

Do you participate in a fitness program, or any sports activities? ε yes ε no If yes, describe:
_____
_____

Has the injury in question hindered or stopped you from doing any of your usual activities? ε yes ε no
If yes, please explain your reasons why: _____
_____
_____
_____
_____

SYSTEMS REVIEW

Circle below if you have any of the following problems:

Heart/Circulation	**Bones/Joints**	**Stomach/Abdomen**	**Urogenital**
High Blood Pressure	Joint Pain	Nausea/Vomiting	Blood in Urine
Chest Pain	Joint Swelling	Peptic Ulcer Disease	Frequency/Urgency
Heart Attack	Stiffness	Pain	Getting up at Night
Swollen Feet		Sudden Weight Loss	Discharge
Poor Healing		Change in Bowel Habits	
		Hernia	
Neurological			
Numbness/Tingling		**Gynecological**	
Headaches		Pelvic Pain	
Coordination Problems	**Emotional/Psychological**		**Other**
Double Vision	Depression	Thoughts of Suicide	
Memory Loss	Anger	Loss of Appetite	
	Anxiety	Unusual stress	

Activity	**Example**
Self-care Personal Hygiene	Urination, Defecating, brushing teeth, Combing hair, Bathing, Dressing oneself, eating
Communication	Writing, Typing, Seeing, Hearing, Speaking
Physical activity	Standing, Sitting, Reclining, Walking
Sensory Function	Hearing, seeing, Tactile feeling, Tasting, Smelling
Non-specialized Hand activities	Grasping, lifting, tactile, discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

Period of Total Temporary Disability: _____

_____

EXAMINEE STATEMENT

The information given in this history questionnaire was provided by me or ( ) through an interpreter, and is true. I ACKNOWLEDGE THAT THE MEDICAL EVALUATION THAT I AM UNDERGOING TODAY IS STRICTLY FOR EVALUATION PURPOSES AND NOT INTENDED FOR TREATMENT.

Examinee's Signature: _____ Date: _____

Interpreter: _____ Agency: _____

Please read the following required disclosure notice:

ARTICLE 4. Evaluation Procedures

§40. Disclosure Requirements: Injured Workers

(a) An evaluator selected from a QME panel shall advise an injured worker prior to or at the time of the actual evaluation of the following:

(1) That he or she is entitled to ask the evaluator and the evaluator shall promptly answer questions about any matter concerning the evaluation process in which the QME and the injured worker are involved;

(2) That subject to section 41(g), the injured worker may discontinue the evaluation based on good cause. Good cause includes: (A) discriminatory conduct by the evaluator towards the worker based on race, sex, national origin, religion, or sexual preference, (B) abusive, hostile or rude behavior including behavior that clearly demonstrates a bias against injured workers, and (C) instances where the evaluator requests the worker to submit to an unnecessary exam or procedure.

(b) When required as a condition of probation by the Administrative Director or his/her licensing authority, the QME shall disclose his/her probationary status. The QME shall be entitled to ex- plain any circumstances surrounding the probation. If at that time, the injured worker declines to proceed with the evaluation, such termination shall be considered by the Administrative Director to have occurred for good cause.

(c) If the injured worker declines to ask any questions relating to the evaluation procedure as set forth in section 40(a), and does not otherwise object on the grounds of good cause to the exam proceedings under section 41(a) during the exam itself, the injured worker shall have no right to object to the QME comprehensive medical-legal evaluation based on a violation of this section.

Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, and 4067 Labor Code.

I have read the above notice: Date: _____

Examinee Name: _____ Examinee Signature: _____

I have read the above notice to the examinee and they fully understand what I read to them:

Interpreter Name: _____ Interpreter Signature: _____

Google

Address **333 San Carlos Way**
Stockton, CA 95207

Notes My office is located in Suite B inside the office of Dr. Scott Inoue D.C.