SIBTF Eligibility General Health Questionnaire

Email to:

adam@qualifiedmedeval.com

Or Mail:

Intake at Qualified Med Eval
3435 E Thousand Oaks Blvd #3157
Thousand Oaks, Ca 91359
916-258-2326

Patient Name:	Steevio Bardakjian			Date of Birth: 05/23/1970	Today's Date: 11/25/2024
Complete Address:	25367 SPLENDIDO CT, STEVENSON RCH, CA 91381				
Phone:	818-406-2639			Social Security Number: 554-81-2130	
Gender:	✓ Male	Female	Working Now:	Yes	No ✓
Email Address:	steevio@steevio.com				
Height:	Feet: 5'	Inches: 11"	Weight: 205 lbs	Date Work Comp Case settled: 08/21/2024	

Please answer the questions below and place an X in the Y (Yes) column, for the below conditions.

Have you had, or do you have these conditions? If yes, please also list the date of onset.

Respiratory - Lungs:	**Y**	Date of Onset		**Psychological:**	Y	Date of Onset
Chronic cough				Stress		
Bronchitis				Depression	X	late 2018
Asthma				Anxiety	X	late 2018
COPD (Chronic Obstructive Pulmonary Disease)				Panic attacks		
Wheezing				Posttraumatic Stress (PTSD)		
Pneumonia				Crying spells	X	late 2018
Tuberculosis				Worry or feeling hopeless		
Emphysema				Suicidal thoughts		
Lung cancer				Phobias - fear of things		
Difficulty breathing				Loss of self-control		
Shortness of breath				Emotional outbursts - anger	X	late 2018
Smoking cigarettes/pipe/chew				Difficultly sleeping	X	late 2018
Blood clot				Fearful of the future	X	late 2018
Sleep apnea - stop breathing				Loss of memory		
Cystic fibrosis				Loss of concentration	X	late 2018
Excessive sputum/spit				Learning difficulties		
Coughing/spitting up blood				Special education classes		
Inhaled particles/lung problem				Dyslexia		
Other:				Difficulty in reasoning		
Skin:				ADD/ADHD		
Pruritus - itching - scratching				Other:		
Scars				**Blood:**		
Skin grafts				Anemia		
Allergy to latex gloves				Spleen disease		
Skin cancer				Blood transfusion		
Burns				Bleeding easily		
Dermatitis - hives				Bruising easily		
Discoloration/pigment changes				Leukemia		
Psoriasis - eczema				Red/white blood cell disorder		
Other:				Other:		
Other conditions not listed:						

Please answer the questions below and place an X in the Y (Yes) column, for the below conditions.

Have you had, or do you have these conditions? If yes, please also list the date of onset.

Endocrine - Glandular:	**Y**	Date of Onset
Diabetes mellitus - Type 1		
Diabetes mellitus - Type 2	X	2013 - present
Taking insulin - diabetes		
Thyroid disease		
Parathyroid disease		
Excessive thirst	X	2013 - present
Testosterone deficiency		
Adrenal disease		
Testicular disease		
Mammary gland disease		
Pancreatic disease		
Other:		
Urinary System:		
Excessive urination	X	2013 - present
Unexpected urination		
Difficulty urinating		
Prostate disease		
Kidney disease/kidney stones		
Bladder disease - infections		
Blood in the urine		
Other:		
Ears - Nose - Throat - Mouth:		
Hearing loss		
Tinnitus (ringing in the ears)	X	2015 - present
Hearing aid(s)		
Allergies/hay fever		
Congestion		
Chronic dry mouth		
Runny nose		
Sinusitis - sinus infections		
Difficulty breathing		
Deviated nasal septum		
Facial disorder - disfigurement		
Diet limited - soft foods/liquids		
Difficulty chewing		
TMJ problem - clicking - pain		
Difficulty speaking/hoarseness		
Dental problems		
Other:		

Gastrointestinal-Digestive:	**Y**	Date of Onset
GERD - acid reflux	X	2018 - present
Esophageal disease		
Barrett's esophagus		
Heartburn		
Bloating		
Nausea	X	2018-present
Vomiting		
Stomach pain		
Stomach pain - taking meds	X	2018 - present
Irritable bowel syndrome (IBS)		
Crohn's disease		
Colitis		
Ulcer		
Gastritis		
Indigestion	X	2013-present
Hernia		
Abdominal mass/protrusion		
Rectal bleeding		
Hemorrhoids		
Bloody stool		
Black stool		
Change in bowel habits	X	2018 - present
Constipation	X	2018 - present
Diarrhea		
Malabsorption syndrome		
Intestinal blockage		
Polyps		
Diverticulosis/diverticulitis		
Obesity		
Recent weight gain		
Recent weight loss		
Perirectal abscess		
Colonoscopy		
Hepatitis		
Liver/gallbladder disease		
Gall stones		
Other:		
Sexual Dysfunction:		
Sexual dysfunction	X	2018 - present
Erectile dysfunction - men		

Please answer the questions below and place an X in the Y (Yes) column, for the below conditions.

Have you had, or do you have these conditions? If yes, please also list the date of onset.

Cardiovascular - Heart:	Y	Date of Onset
Heart attack	X	April 2021
Valve disease		
Valve replacement		
Pacemaker		
High blood pressure (hypertension)	X	2013 - present
Racing heartbeat		
Chest/jaw/arm pain-pressure		
Heart murmur		
Angina	X	2020
Palpitations - pounding heart	X	2020
Congestive heart failure		
Heart defect/disease		
Coronary artery disease	X	April 2021
Arrhythmia - AFib		
Pericardial heart disease		
Blood clot		
Deep vein thrombosis (DVT)		
Vascular disease		
Aortic disease		
Swelling in the legs	X	2020
Other:		
Fractures:		
Upper extremity		
Lower extremity		
Torso - ribs - chest		
Pelvis		
Spine		
Cranium - skull - face		
Other:		
Headaches:		
Migraine		
Cluster		
Cervical - muscle tension		
Post-traumatic		
Menopausal		
Sinus		
Stress		
Rebound from taking medicine		

Vision:	Y	Date of Onset
Decreased vision		
Blurry vision		
Glasses	X	1994
Contacts	X	2012
Glaucoma		
Astigmatism		
Diabetic retinopathy	X	2024
Cornea abrasion		
Cataracts		
Detached/torn retina		
Inflammation eye - or eye lid		
Dry eyes		
Macular degeneration		
Other:		
Arthritis:		
Osteoarthritis	X	2022
Rheumatoid		
Lupus		
Gout		
Psoriasis		
Other:		
General:		
Surgeries	X	2018, 2021, 2022
Hospitalization	X	2018, 2021, 2022
STD - venereal disease		
HIV/AIDS		
Epilepsy		
Seizures		
Fainting		
Stroke		
TIA (mini stroke)		
Cancer		
Bone problems	X	2018-present
Joint problems	X	2018-present
Muscle problems		
Amputations		
Paralysis		
Hysterectomy		

If you checked Y **(Yes)** to any of the above conditions (Pages 1 - 3) answer the questions below

List below the doctors - facilities - hospitals - clinics that treated/evaluated you with city and address and phone number

Doctor-facility-hospital-clinic name:	City:	Phone number and Address if known:
FACEY MEDICAL GROUP	VALENCIA	661-222-2600, 26357 McBEAN PKWY, VALENCIA, 91355
PHILIP CONWISAR, MD	SHERMAN OAKS	818-784-1354, 4835 VAN NUYS BLVD, SHERMAN OAKS, CA 91403
UNIVERSAL PAIN MANAGEMENT	VALENCIA	661-367-9788, 28212 KELLY JOHNSON PKWY, #155, VALENCIA, 91355
LEE WOODS, DM	WHITTIER	562-907-7682, 13113 HADLEY ST, WHITTIER, CA, 90601
VALLEY PRESBYTERIAN HOSPITAL	VAN NUYS	818-782-6600, 15107 VANOWEN ST, VAN NUYS, CA 91405
HENRY MAYO HOSPITAL	VALENCIA	661-200-2000, 23845 McBEAN PKWY, VALENCIA, CA 91355
VARGO PHYSICAL THERAPY	VALENCIA	661-259-2621, 25830 McBEAN PKWY, VALENCIA, 91355
JESSICA CAO, MD	VALENCIA	661-705-1075, 23929 McBEAN PKWY, #208, VALENCIA, CA 91355
SAIF USMAN, MD	VALENCIA	661-481-2400, 23803 McBEAN PKWY, #101, VALENCIA, CA 91355

Information About Your '<u>Last</u>' Work Injury

Employer name:	OLIVE VIEW MEDICAL CENTER	Date of work injury:	07/03/2018			
Are you still working for this employer? I AM ON LONG TERM MEDICAL LEAVE					Yes	X	No
If no, what was the last date you worked at this employment?			AUGUST, 2023			

Please describe the body parts that were injured because of this work injury:	
1. LUMBAR SPINE	6.
2. R-KNEE	7.
3.	8.
4.	9.
5.	10.

Please list the permanent disability rating because of this work injury, if known:	53%	%

Are you still getting medical care for this injury?	X	Yes		No
If yes, please describe the treatment that you are receiving below:				
1. LUMBAR SPINE DISCECTOMY/LAMINECTOMY IN 2018				
2. R-KNEE MENISCUS REAIR SURGERY IN 2022				
3. PHYSICAL THERAPY FOR LUMBAR SPINE INJURY SINCE 2019 TO PRESENT				
4. PAIN MANAGEMENT SINCE 2019 TO PRESENT				
5. ONGOING CONSULTATIONS TO PREPARE FOR 360-LUMBAR FUSION SURGERY L3-S1				
6.				
7.				

Information About Your Health 'Before' Your Last Work Injury

Did you have any conditions, difficulties or health problems **before** the work injury?	X	Yes		No

If yes, please list all your **prior** conditions, illnesses, limitations, difficulties, or health concerns below.

1. HYPERTENSION	8.
2. DIABETES TYPE 2	9.
3. HYPERLIPIDEMIA	10.
4.	11.
5.	12.
6.	13.
7.	14.

Any **prior** problems with your upper or lower extremities, eyes, ears, kidneys, or Jaw?	X	Yes		No

If yes, answer the questions below and place an X in the **Y** (Yes) column, with the date of onset:

Bilateral Conditions:	**Y**	Date of Onset	**Bilateral Conditions:**	**Y**	Date of Onset
Right shoulder			Right hip		
Left shoulder			Left hip		
Right arm			Right groin		
Left arm			Left groin		
Right elbow			Right thigh		
Left elbow			Left thigh		
Right forearm			Right knee		
Left forearm			Left knee	X	2016
Right wrist			Right calf - shin		
Left wrist			Left calf - shin		
Right hand - fingers			Right ankle		
Left hand - fingers			Left ankle		
Right eye	X	1993	Right foot - toes		
Left eye	X	1993	Left foot - toes		
Right ear	X	2014	Right kidney		
Left ear			Left kidney		
Right TMJ – Jaw (Temporomandibular joint)			Left TMJ – Jaw (Temporomandibular joint)		

Current Home Care

X	Ice	X	Heat	X	T.E.N.S. unit		H-wave
X	Stretches - exercises	X	Blood testing		Bedrest	X	Medication
	Paraffin bath		Home care help/aid		Compression stocking	X	Injections
	No home care	Other:	ASSISTIVE DEVICES FOR AMBULATION WHEN NEEDED				

Please describe current home care below:
1. CONTINUE PHYSICAL THERAPY AT HOME
2. MY WIFE ASSISTS ME ON MANY OF THE DAILY ACTIVITIES WHEN NEEDED
3.
4.

Current Aids

X	Walker		Wheelchair	X	Cane(s)	X	Crutch(es)
	Scooter		Dentures		Night guard	X	Glasses - contacts
	Bed incline		Pacemaker	X	Support - brace		Hearing aid(s)
	Colostomy bag		Sleeping device		Breathing device		Boot - brace
	No current aids	Other:					

Source of medication:		Over the counter		Prescription	X	Both	

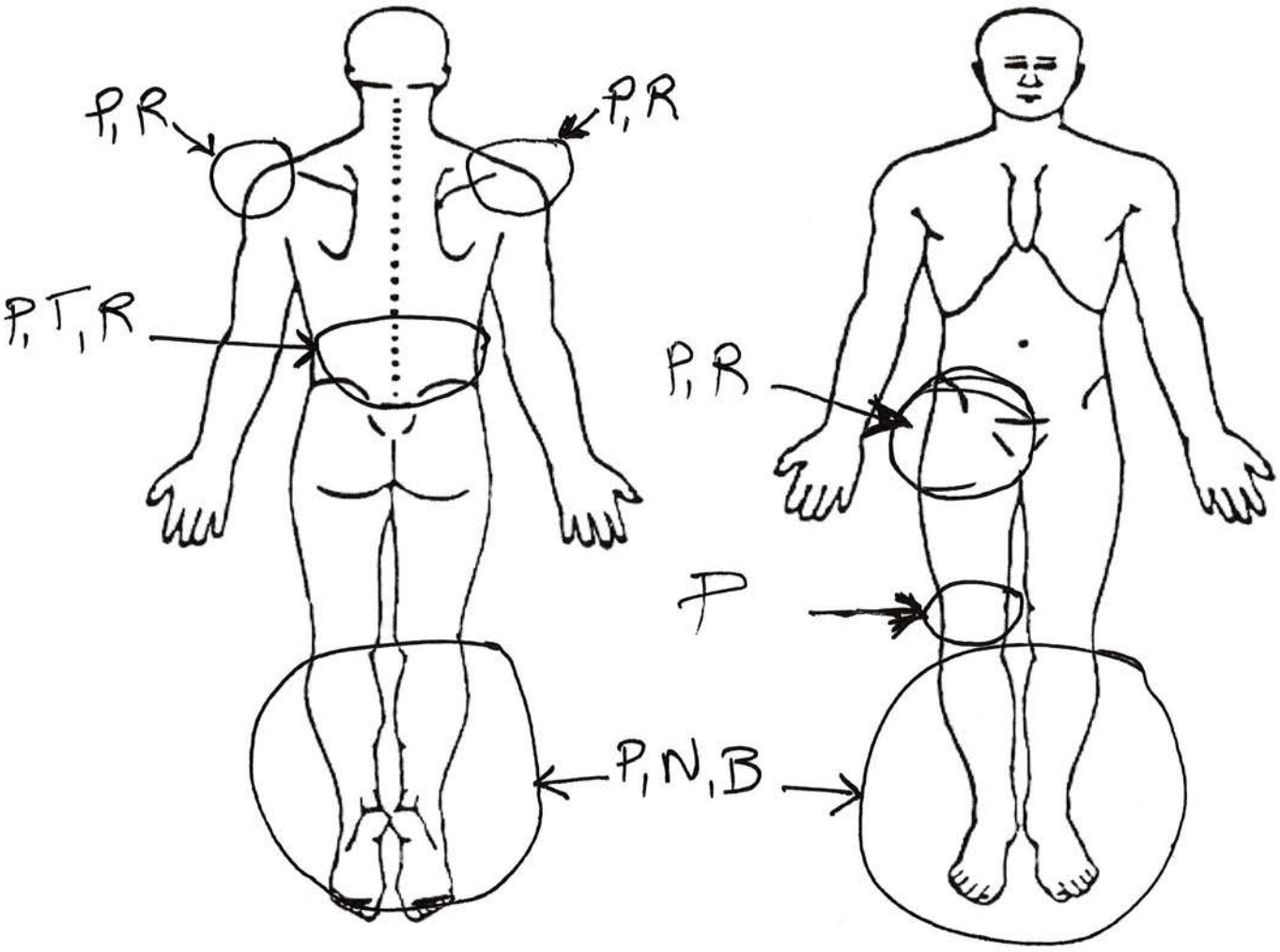
Please list names of all medications taken currently:	How often is the medication taken?
1. OZEMPIC	ONE INJECTION PER WEEK
2. LOSARTAN	ONCE PER DAY
3. JARDIANCE	ONCE PER DAY
4. CRESTOR	ONCE PER DAY
5. MOVANTICK	ONCE PER DAY
6. OXYCODONE-ACETAMINOPHEN #10	TWICE PER DAY
7. CHOLECALCIFEROL	ONCE PER DAY
8. ASPIRIN	ONCE PER DAY
9. B-COMPLEX	ONCE PER DAY

Surgical History

Please list all surgeries:	Location:	Date surgery was performed?
1. LUMBAR SPINE SURGERY	VALLEY PRESBYTERIAN HOSPITAL	AUGUST, 2018
2. OPEN HEART SURGERY	HENRY MAYO HOSPITAL	JULY, 2021
3. R-KNEE SURGERY	RADIANCE SURGERY CENTER	MAY, 2022
4.		
5.		
6.		
7.		
8.		
9.		

Symptom Diagram
Mark the areas on your body where you are having symptoms

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



Patient Signature: _____

Date: 11 / 25 / 2024 Patient Phone # 818-406-2639