QME | QUALIFIED MED EVAL

SIBTF Eligibility General Health Questionnaire

Email to:

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Or Mail:

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

Patient Name:	Moore Branden E			Date of Birth: 05/12/1990	Today's Date: 11/25/2024
Complete Address:	292 Finnhorse St Hemet Ca. 92545				
Phone:	601 383 7707			Social Security Number: 366 11 1170	
Gender:	(Male)	Female	Working Now:	Yes	(No)
Email Address:	Brandenmoore22@yahoo.com				
Height:	Feet: 6	Inches: 0	Weight: 170	Date Work Comp Case settled:	

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		
Asthma			Anxiety	/	
COPD (Chronic Obstructive Pulmonary Disease)			Panic attacks		
Wheezing			Posttraumatic Stress (PTSD)	/	
Pneumonia			Crying spells		
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	/	
Smoking cigarettes/pipe/chew			Difficultly sleeping	/	
Blood clot			Fearful of the future	/	
Sleep apnea - stop breathing			Loss of memory	/	
Cystic fibrosis			Loss of concentration	/	
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		
Taking insulin - diabetes		
Thyroid disease		
Parathyroid disease		
Excessive thirst	/	
Testosterone deficiency		
Adrenal disease		
Testicular disease		
Mammary gland disease		
Pancreatic disease		
Other:		
Urinary System:		
Excessive urination	/	
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)	/	
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		
Esophageal disease		
Barrett's esophagus		
Heartburn	/	
Bloating	/	
Nausea	/	
Vomiting	/	
Stomach pain	/	
Stomach pain - taking meds	/	
Irritable bowel syndrome (IBS)	/	
Crohn's disease		
Colitis		
Ulcer		
Gastritis		
Indigestion		
Hernia		
Abdominal mass/protrusion		
Rectal bleeding		
Hemorrhoids	/	
Bloody stool		
Black stool		
Change in bowel habits	/	
Constipation	/	
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	/	
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		
Valve disease		
Valve replacement		
Pacemaker		
High blood pressure (hypertension)		
Racing heartbeat		
Chest/jaw/arm pain-pressure		
Heart murmur	/	
Angina		
Palpitations - pounding heart		
Congestive heart failure		
Heart defect/disease		
Coronary artery disease		
Arrhythmia - AFib		
Pericardial heart disease		
Blood clot		
Deep vein thrombosis (DVT)		
Vascular disease		
Aortic disease		
Swelling in the legs		
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		
Contacts		
Glaucoma		
Astigmatism		
Diabetic retinopathy		
Cornea abrasion		
Cataracts		
Detached/torn retina		
Inflammation eye - or eye lid		
Dry eyes	/	
Macular degeneration		
Other:		
Arthritis:		
Osteoarthritis		
Rheumatoid		
Lupus		
Gout		
Psoriasis		
Other:		
General:		
Surgeries		
Hospitalization		
STD - venereal disease		
HIV/AIDS		
Epilepsy		
Seizures		
Fainting		
Stroke		
TIA (mini stroke)		
Cancer		
Bone problems		
Joint problems	/	
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:
San Gregonia Hospital	San Gregonia	
San Diego VAMC	LA Jolla	

Information About Your 'Last' Work Injury

Employer name:	Abercrombie Pipeline	Date of work injury:	5/28/2020
Are you still working for this employer?			☐ Yes ☒ No
If no, what was the last date you worked at this employment?			5/28/2020

Please describe the body parts that were injured because of this work injury:	
1. Muscular	6.
2. Joint	7.
3. Skeletal	8.
4. Internal	9.
5.	10.

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

Are you still getting medical care for this injury?	☒ Yes	☐ No
If yes, please describe the treatment that you are receiving below:		
1. Gabapintin		
2. Chiropractor		
3. Chelation Therapy Private		
4. Physical Therapy Private		
5.		
6.		
7.		

Information About Your Health 'Before' Your Last Work Injury

Did you have any conditions, difficulties or health problems **before** the work injury?		Yes		No
If yes, please list all your **prior** conditions, illnesses, limitations, difficulties, or health concerns below.				
1. WPW	8.			
2. Anxiety	9.			
3. Tennis	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		
Right wrist			Right calf - shin		
Left wrist			Left calf - shin		
Right hand - fingers			Right ankle		
Left hand - fingers			Left ankle		
Right eye			Right foot - toes		
Left eye			Left foot - toes		
Right ear			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		Blood testing	X	Bedrest	X	Medication
	Paraffin bath		Home care help/aid		Compression stocking		Injections
	No home care	Other:					

Please describe current home care below:
1. Medication
2. Diet
3. Rest
4. PT

Current Aids

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

Source of medication:		Over the counter		Prescription		Both

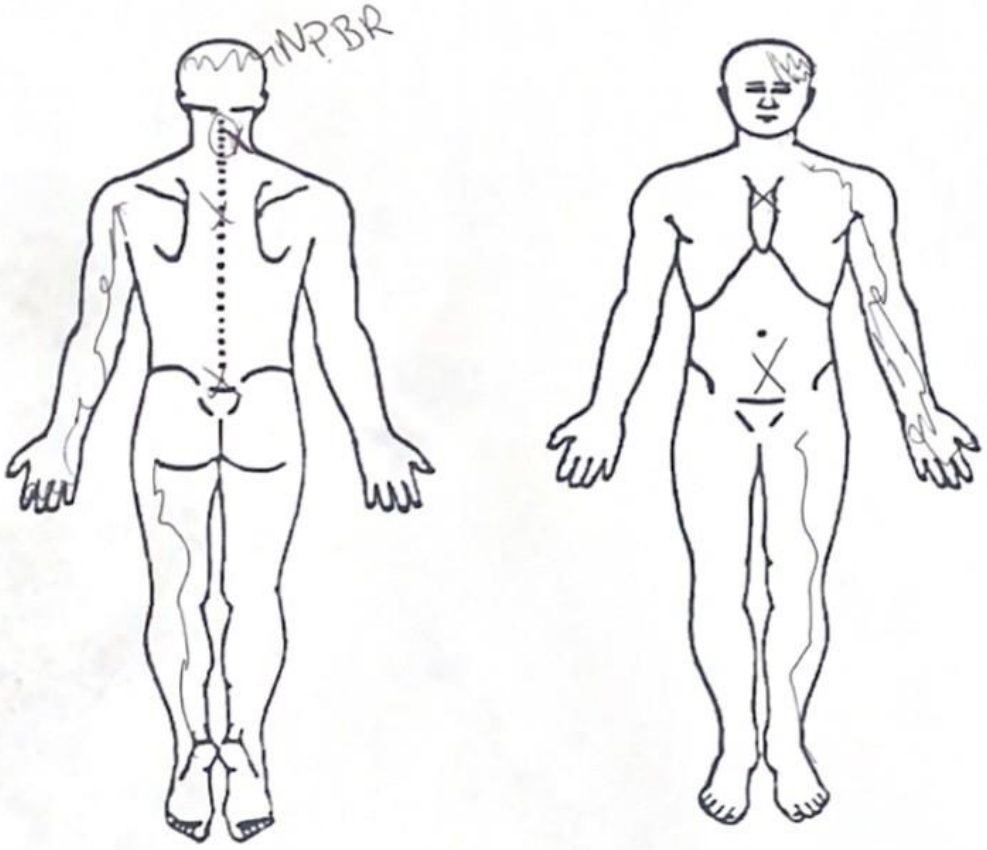
Please list names of all medications taken currently:	How often is the medication taken?
1. Gabapentin	Daily
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Surgical History

Please list all surgeries:	Location:	Date surgery was performed?
1. Ablation	SDVA	2014
2.		
3.		
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 # _____