# CRAIG H. ROSEN M.D., P.A.

*Orthopedic Surgery*

Welcome to the office of Dr. Craig H. Rosen, a board-certified orthopedic surgeon and a member of the AAOS (American Academy of Orthopedic Surgeons). This evaluation has been requested by an attorney or insurance company. During your evaluation, you will be treated with courtesy, dignity, and respect. Please understand that this does not constitute a doctor-patient relationship and that no treatment will be instituted at this time. A report will be generated after your history is taken, an examination is performed, and Dr. Rosen can review the appropriate diagnostic studies. The conclusions will be based upon these issues and will be a fair and honest report regarding all parties involved.

Enclosed you will find the necessary paper work to complete your evaluation. If possible, please have these forms filled out prior to your appointment. You will also be asked to provide a photo ID. A signature on the form titled **Examinee ID for IME** and a signature on the form **Symptom Diagram of Musculoskeletal System** is required. If these forms are not signed, your evaluation will not be completed and a fee will be charged to your attorney or insurance company. Please feel free to have your attorney or insurance company review these forms and call us with any questions or concerns.

You will be asked to fill out a short exit survey. If there are any questions upon your departure (except in regard to treatment) please feel free to ask our staff.

Thank you for your cooperation.

Sincerely,

Craig H. Rosen, MD

Main Office • 9 Eves Drive, Ste 165 • Marlton, NJ 08053 • Main: 856-988-9400 • Fax: 856-988-9600 • IME: 856-988-9700
1999 New Road, Suite B • Linwood, NJ 08221

# CRAIG H. ROSEN M.D., P.A.

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## Examinee ID for IME

Patient Name: _____ DOB: _____

Home Phone: _____ Atty/Ins Phone: _____

Chief Complaint: _____

Driver's License Number: _____

Date of Injury: _____ Type: (please circle) MVA WC Slip/Fall

### Relationship, Release, & Identity

I understand I am undergoing a medical examination and/or evaluation at the request of an attorney, employer, a physician, or an insurance company. I understand that Craig H. Rosen, M.D. will not serve as my primary or consulting physician. I understand that no doctor/patient relationship will be established if I am here for an Independent Medical Examination and/or other evaluations where no treatment is to be given. If I were here for treatment, I would have a doctor/patient relationship.

I authorize and release Craig H. Rosen, M.D. to discuss information concerning the results of the medical examination performed on _____ to any third party, and to testify without limitation, as to all findings of said medical examination/evaluation if any legal action, judicial or administrative proceedings to which I am, or may become, a party or in which I have any interest. I waive on behalf of myself and any persons who may have interest in this matter, all provisions of law, if any, relating to the disclosure of information acquired through such examination.

By signing this form, the picture ID I have produced confirms my identity.

_____ _____

IME Signature Date

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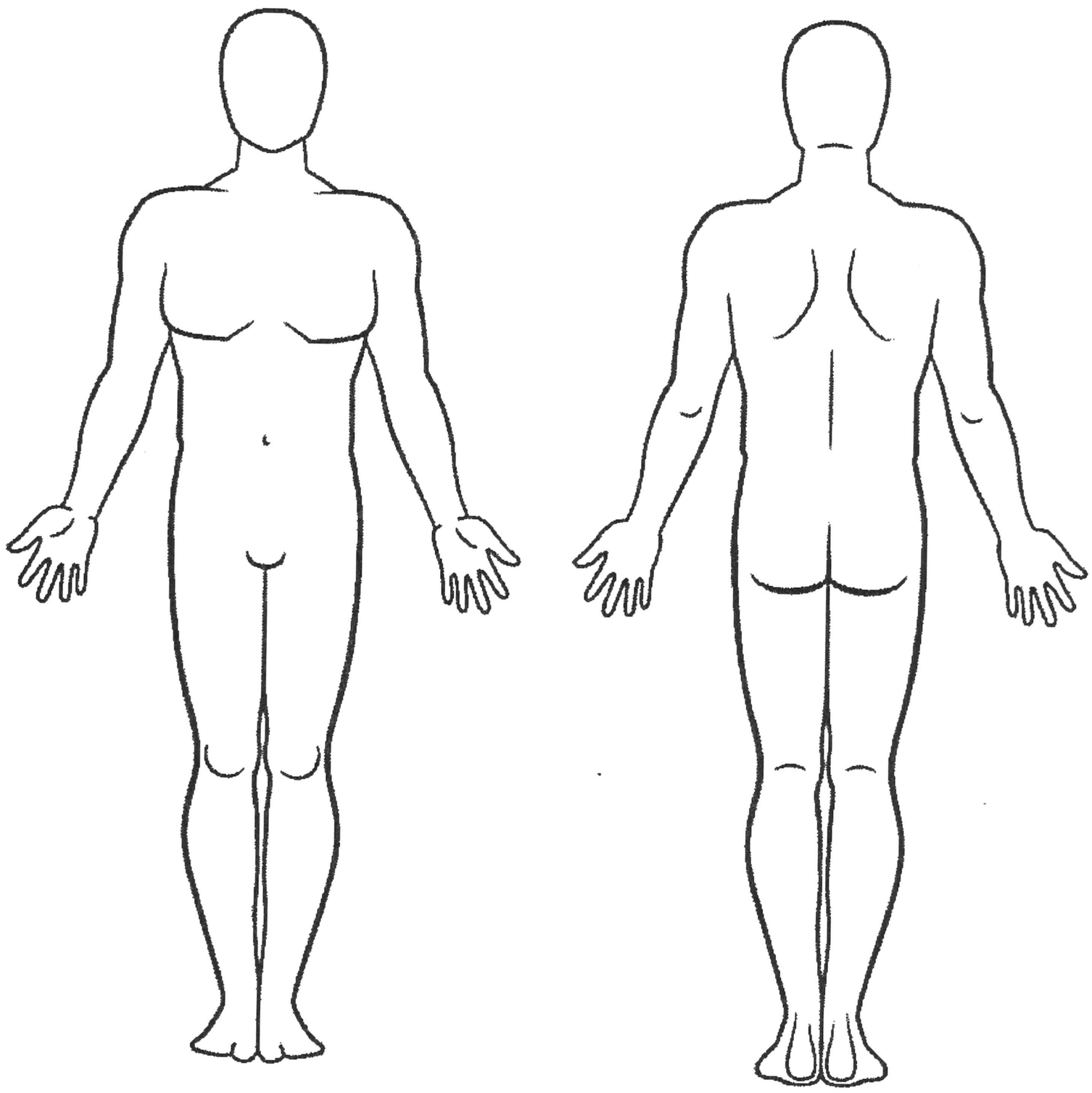
## Symptom Diagram of Musculoskeletal System

Name: _____ Date: _____

**PLEASE CIRCLE: PAIN AND NUMBNESS – AREA(S) OF INJURY**



**FRONT** **BACK**

Examinee Signature (required): _____

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**CRAIG H. ROSEN, MD** **Orthopedic Surgery**

Please place an "X" in the box which best describes your usual activities OVER THE PAST WEEK

| | Without Difficulty | With Some Difficulty | With Much Difficulty | Unable to Do |
|---|---|---|---|---|
| **Self Care - Are you able to:** | | | | |
| Dress yourself including shoes | | | | |
| Comb your hair | | | | |
| Wash and dry yourself | | | | |
| Take a bath | | | | |
| Get on and off the toilet | | | | |
| Brush your teeth | | | | |
| Cut your food | | | | |
| Lift a full cup/glass to your mouth | | | | |
| Open a new milk carton | | | | |
| Make a meal | | | | |
| **Communication - Are you able to:** | | | | |
| Write a note | | | | |
| Type a message on the computer | | | | |
| See a television screen | | | | |
| Use a telephone | | | | |
| Speak clearly | | | | |
| **Physical Activity - Are you able to:** | | | | |
| Walk outdoors on flat ground | | | | |
| Climb up 1 flight of 10 steps | | | | |
| Stand | | | | |
| Sit | | | | |
| Recline | | | | |
| Rise from a chair | | | | |
| Run errands | | | | |
| Light housework | | | | |
| **Sensory - Are you able to:** | | | | |
| Feel what you touch | | | | |
| Smell what you eat | | | | |
| Taste the food you eat | | | | |
| **Hand Activities - Are you able to:** | | | | |
| Open car doors | | | | |
| Open previously opened jars | | | | |
| Turn faucets on and off | | | | |
| **Travel - Are you able to:** | | | | |
| Shop | | | | |
| Get in and out of a car | | | | |
| **Sleep - Are you able to:** | | | | |
| Sleep | | | | |
| Engage in sexual activity | | | | |

**Other restrictions you have** _____

_____

**What has changed in your lifestyle?** _____

_____

_____

**For office staff only: Total score** _____

Signature of Examinee or Patient: _____

**CRAIG H. ROSEN, M.D. Orthopedic Surgery**

Name: _____ Date: _____

Address: _____ Age: _____

SS# _____ DOB: _____ DOI: _____

**PAST MEDICAL HISTORY:** (Check those that apply)

- ❑ Hypertension
- ❑ Heart Disease
- - Pacemaker - Heart Attack
- - Stents - Arrhythmia
- - Valve
- ❑ Fractures
- ❑ Diabetes
- ❑ High Cholesterol
- ❑ Asthma
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Hepatitis/HIV
- ❑ Rheumatoid Arthritis
- ❑ Reflux, Peptic Ulcers
- ❑ Phlebitis/DVT/Blood Clots
- ❑ Cancer
- ❑ Thyroid Disease
- ❑ Arthritis: Where? _____
- ❑ Kidney Disease
- ❑ TB
- ❑ Gout
- ❑ Psoriasis
- ❑ Stroke

**PAST SURGICAL HISTORY:** ❑ None

_____

_____

**MEDICATIONS:** (Include vitamins and supplements)

_____

_____

_____

_____

**MEDICATION ALLERGIES:**

_____

_____

_____

**SOCIAL HISTORY:**

❑ Drugs: _____ ❑ Smoking: _____ packs/day ❑ Alcohol _____ #/day

Sports/Hobbies/Night & Weekend Activities: (time with each) _____

Last Grade Completed in School: _____

Living Situation: With Someone? _____ Number of Floors/Stairs: _____

**FAMILY HISTORY:** Any of the conditions noted above in your family? _____

_____

**HOSPITALIZATIONS:** _____

**WORK STATUS:** Occupation: _____ Currently Working? Yes or No

Time (and date) Lost From Work: _____

**CRAIG H. ROSEN, M.D. Orthopedic Surgery**

Name: _____

REVIEW OF SYSTEMS: Include numbness, tingling, weakness, bowel/bladder problems, sexual difficulties, etc. Do you now or have you had any problems related to the following systems? Circle Yes or No.

**Explain any YES answers in the space provided. Unanswered questions are considered a NO.**

Constitutional Systems

| | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headaches | Y | N |
| Other _____ | | |

Eyes

| | | |
|---|---|---|
| Blurred Vision | Y | N |
| Double Vision | Y | N |
| Pain, white of eye-Jaundice | Y | N |
| Other _____ | | |

Allergic/Immunologic

| | | |
|---|---|---|
| Hay Fever | Y | N |
| Drug Allergies | Y | N |
| Other _____ | | |

Neurological

| | | |
|---|---|---|
| Tremors | Y | N |
| Dizzy Spells | Y | N |
| Numbness/Tingling | Y | N |
| Circle: Upper or Lower Extremities | | |

Endocrine

| | | |
|---|---|---|
| Excessive Thirst | Y | N |
| Too Hot/Cold | Y | N |
| Tired/Sluggish | Y | N |
| Other _____ | | |

Gastrointestinal

| | | |
|---|---|---|
| Abdominal Pain | Y | N |
| Nausea/Vomiting | Y | N |
| Indigestion/Heartburn | Y | N |
| Other _____ | | |

Cardiovascular

| | | |
|---|---|---|
| Chest Pain | Y | N |
| Varicose Veins/Phlebitis | Y | N |
| High Blood Pressure | Y | N |
| Other Heart Problem | Y | N |
| Stents | Y | N |
| Pacemaker/Difibrillator | Y | N |

Integumentary

| | | |
|---|---|---|
| Skin Rash | Y | N |
| Lesions, Spots | Y | N |
| Persistent Itch | Y | N |
| Other _____ | | |

Musculoskeletal

| | | |
|---|---|---|
| Joint Pain | Y | N |
| Neck Pain | Y | N |
| Back Pain | Y | N |
| Other _____ | | |

Ear/Nose/Throat/Mouth

| | | |
|---|---|---|
| Ear Infection | Y | N |
| Sore Throat | Y | N |
| Sinus Problems | Y | N |
| Other _____ | | |

Genitourinary

| | | |
|---|---|---|
| Urine Retention | Y | N |
| Painful Urination | Y | N |
| Urinary Frequency | Y | N |
| Other _____ | | |

Respiratory

| | | |
|---|---|---|
| Wheezing | Y | N |
| Frequent Cough | Y | N |
| Shortness of Breath | Y | N |
| COPD or Asthma | Y | N |
| Other _____ | | |

Hematological/Lymphatic

| | | |
|---|---|---|
| Swollen Glands/Neck Mass | Y | N |
| Blood Clotting Problem | Y | N |
| Other _____ | | |

Psychiatric

| | | |
|---|---|---|
| Depression | Y | N |
| Anxiety, Agitation | Y | N |
| Aware of Time, Person, and Place | Y | N |

Comments/Notes: Chief Complaint (in 10 words or less):

Pain Scale: Low (0) & High (10) _____ (0 to 10) Height _____ Weight _____

Examinee's or Patient's Signature: _____

Physician's Signature: _____