# DAYTON PUBLIC SCHOOLS
# MEDICAL QUESTIONNAIRE

## TO BE COMPLETED BY EMPLOYEE

Employee Group _________________

1. Name ________________________________Birthdate ______________________ Male _____ Female ____
   Employment date __________ Social Security No. __________________Home Phone # _________________
2. HomeAddress_____________________________________________________________________________
   (street) (city) (state) (zip)
   If you are or expect to be elsewhere during absence from work, give details including address and telephone number.
   ________________________________________________________________________________________
   ________________________________________________________________________________________
   (street) (city) (state) (zip)
3. Please explain your catastrophic illness or injury. Give a detailed description. (Use a separate sheet if necessary.)
   ________________________________________________________________________________________
   ________________________________________________________________________________________
   ________________________________________________________________________________________
4. On what date did you last work? __________________________, 20_____
5. On what date were you first totally disabled by this catastrophic illness/injury? ________, 20___
6. On what date were you first treated by a physician for this catastrophic illness/injury? ________
7. If not now afflicted by the catastrophic illness/injury, on what date were you able to resume work? _______________, 20 ___.
8. Give full name and address of <u>each</u> physician who treated you during this period of disability:
   <u>NAME</u> <u>ADDRESS</u>
9. Explanation of Previous Sick Leave Usage (Use separate sheet)
10. Date Sick Leave was (will be) exhausted. _____________________________________________
11. Have you applied for disability? _______________ Workman's Comp? ___________________

I authorize any physician, surgeon, or other person who has treated or examined me or whom I have consulted for any purpose, and any hospital, clinic, or institution at which I have been treated, examined, or confined, to divulge and make available to Dayton Public Schools, or their designated representatives, any and all information concerning my catastrophic illness/injury including all psychiatric and psychological information and tests. This authorization shall be valid for one year from the date shown below. A photocopy of this authorization shall be as valid as the original.

Date completed ________________, 20 ____ Signature of Employee ____________________________

**TO BE COMPLETED BY ATTENDING PHYSICIAN**
**(Please type or print.)**

1. Patient's Name ______________________________________________________ Age ________

2. Please state:
   (a) Patient's complaints ______________________________________________________
   ______________________________________________________________________________

   (b) Objective finding (Including results of X-rays, laboratory tests, diagnostic studies, B/P, etc., if relevant) ______________________________________________________________
   ______________________________________________________________________________

3. Give all dates of treatments by you during this period of catastrophic illness/injury:
   Office: ________________________________________________________________________
   Hospital: ______________________________________________________________________

4. If the patient was confined as a registered bed patient in a legally constituted hospital during this period, answer the following:
   (a) Name & address of hospital or facility _____________________________________________
   (b) Date of admission _______________________, 20 ___ Date of discharge _________, 20_____

5. If any surgical procedure was performed during this period of catastrophic illness or injury, please complete the following:

   Date of procedure _________________, 20 ___ Procedure performed ___________________
   ______________________________________________________________________________
   ______________________________________________________________________________

6. Has the patient recovered sufficiently to return to work? YES _____ NO _______
   (a) If "yes", give the date the patient was able to return to work. _____________________________
   (b) If "no", when, in your opinion, may work be resumed? (Please do not use the terms "Indefinite", "Unknown", "Undetermined", etc.) If a definite date cannot be determined, please approximate in days, weeks or months, how long the total disability will continue from the date of the most recent treatment as indicated above.

   ______________________________________________________________________________

7. Is the patient MENTALLY capable of transacting his/her duties with the realization of the nature and consequences of such acts? YES ______ NO ______

Physician's name and title (Please print) ____________________________________________

Specialty Board Certification ______________________________Phone #_____________________

Office Address _________________________________________________________________

Date Completed _______________________ Physician's Signature __________________________