GHITTERMAN, GHITTERMAN & FELD
ATTORNEYS AT LAW

418 EAST CANON PERDIDO STREET
SANTA BARBARA, CALIFORNIA 93101
TELEPHONE (805) 965-4540
FACSIMILE (805) 965-5009
e-mail workcomp@ghitterman.com

ALLAN S. GHITTERMAN (1924-2018)
RUSSELL R. GHITTERMAN*
BENJAMIN P. FELD*
JAN ERIC KAESTNER
JILL A. SINGER*
CELESTE C. TORRES
VALARIE C. GROSSMAN
RANCHAELA H. WARD**
*Certified specialist, workers' compensation
The State Bar of California Legal Specialists
**Admitted to practice in Louisiana only

HEARING REPRESENTATIVES
ARMANDO DI FILIPPO
ALICIA LIERA RODRIGUEZ
FRANCISCO RODRIGUEZ

SIBTF General Health Questionnaire

Patient name:			Date of birth:	
Address:			SSN:	
Phone:			Working currently?	
Gender:			Height:	
Interpreter name:			Weight:	
Today's Date:			Attorney:	Ghitterman, Ghitterman, & Feld

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		**Gastrointestinal-Digestive:**	**Y**	Date of onset
Diabetes mellitus - Type 1				GERD - acid reflux		
Diabetes mellitus - Type 2				Esophageal disease		
Taking insulin - diabetes				Barrett's esophagus		
Thyroid disease				Heartburn		
Parathyroid disease				Bloating		
Excessive thirst				Nausea		
Testosterone deficiency				Vomiting		
Adrenal disease				Stomach pain		
Testicular disease				Stomach pain - taking meds		
Mammary gland disease				Irritable bowel syndrome (IBS)		
Pancreatic disease				Crohn's disease		
Other:				Colitis		
				Ulcer		
Urinary System:				Gastritis		
Excessive urination				Indigestion		
Unexpected urination				Hernia		
Difficulty urinating				Abdominal mass/protrusion		
Prostate disease				Rectal bleeding		

Kidney disease/kidney stones			Hemorrhoids		
Bladder disease - infections			Bloody stool		
Blood in the urine			Black stool		
Other:			Change in bowel habits		
			Constipation		
Ears - Nose - Throat - Mouth:			Diarrhea		
Hearing loss			Malabsorption syndrome		
Tinnitus (ringing in the ears)			Intestinal blockage		
Hearing aid(s)			Polyps		
Allergies/hay fever			Diverticulosis/diverticulitis		
Congestion			Obesity		
Chronic dry mouth			Recent weight gain		
Runny nose			Recent weight loss		
Sinusitis - sinus infections			Perirectal abscess		
Difficulty breathing			Colonoscopy		
Deviated nasal septum			Hepatitis		
Facial disorder - disfigurement			Liver/gallbladder disease		
Diet limited - soft foods/liquids			Gall stones		
Difficulty chewing			Other:		
TMJ problem - clicking - pain					
Difficulty speaking/hoarseness			**Sexual Dysfunction:**		
Dental problems			Sexual dysfunction		
Other:			Erectile dysfunction - men		
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.

Cardiovascular - Heart:	**Y**	Date of onset	**Vision:**	**Y**	Date of onset
Heart attack			Decreased vision		
Valve disease			Blurry vision		
Valve replacement			Glasses		
Pacemaker			Contacts		
High blood pressure (hypertension)			Glaucoma		
Racing heart beat			Astigmatism		
Chest/jaw/arm pain-pressure			Diabetic retinopathy		
Heart murmur			Cornea abrasion		
Angina			Cataracts		
Palpitations - pounding heart			Detached/torn retina		

Congestive heart failure				Inflammation eye - or eye lid		
Heart defect/disease				Dry eyes		
Coronary artery disease				Macular degeneration		
Arrhythmia - AFib				Other:		
Pericardial heart disease						
Blood clot				**Arthritis:**		
Deep vein thrombosis (DVT)				Osteoarthritis		
Vascular disease				Rheumatoid		
Aortic disease				Lupus		
Swelling in the legs				Gout		
Other:				Psoriasis		
				Other:		
Fractures:						
Upper extremity				**General:**		
Lower extremity				Surgeries		
Torso - ribs - chest				Hospitalization		
Pelvis				STD - venereal disease		
Spine				HIV/AIDS		
Cranium - skull - face				Epilepsy		
Other:				Seizures		
				Fainting		
Headaches:				Stroke		
Migraine				TIA (mini-stroke)		
Cluster				Cancer		
Cervical - muscle tension				Bone problems		
Post-traumatic				Joint problems		
Menopausal				Muscle problems		
Sinus				Amputations		
Stress				Paralysis		
Rebound from taking medicine				Hysterectomy		
Other:				Other:		
Other conditions not listed:						

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

Doctor-facility-hospital-clinic name:	City:	Address if known:

Information About Your 'Last' Work Injury

Employer name:		Date of work injury:			
Are you still working for this employer?				Yes	No
If no, what was the last date you worked at this employment?					

Please describe the body parts that were injured as a result of this work injury:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list the permanent disability rating as a result 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.				
2.				
3.				
4.				
5.				
6.				

Information About Health '**<u>Before</u>**' 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.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Any **prior** problems with your upper or lower extremities or eyes?		Yes		No

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

Conditions:	**<u>Y</u>**	Date of Onset		**Conditions:**	**<u>Y</u>**	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		

Current Home Care

	Ice		Heat		T.E.N.S. unit		H-wave
	Stretches - exercises		Blood testing		Bedrest		Medication
	Paraffin bath		Home care help/aid		Compression socks		Injections
	No home care	Other:					

Please describe current home care below:
1.
2.
3.
4.
5.
6.

Current Aids

	Walker		Wheel Chair		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:					

Please describe all aids used currently:	How often is it being used?
1.	
2.	
3.	
4.	

Current Medication

	Pain medication		Muscle relaxer		Anti-inflammatory		Sleep medication
	Pain cream		Pain patch		Morphine pump		Heart medication
	Blood thinner		Hormones		High blood pressure		Inhaler
	Oxygen		Mood stabilizer		Seizure		Eye drops
	Anti-diarrheal		Stool softener		Antacid		Insulin
	No current medicine	Other:					

Source of medication:		Over-the-counter		Prescription		Both

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

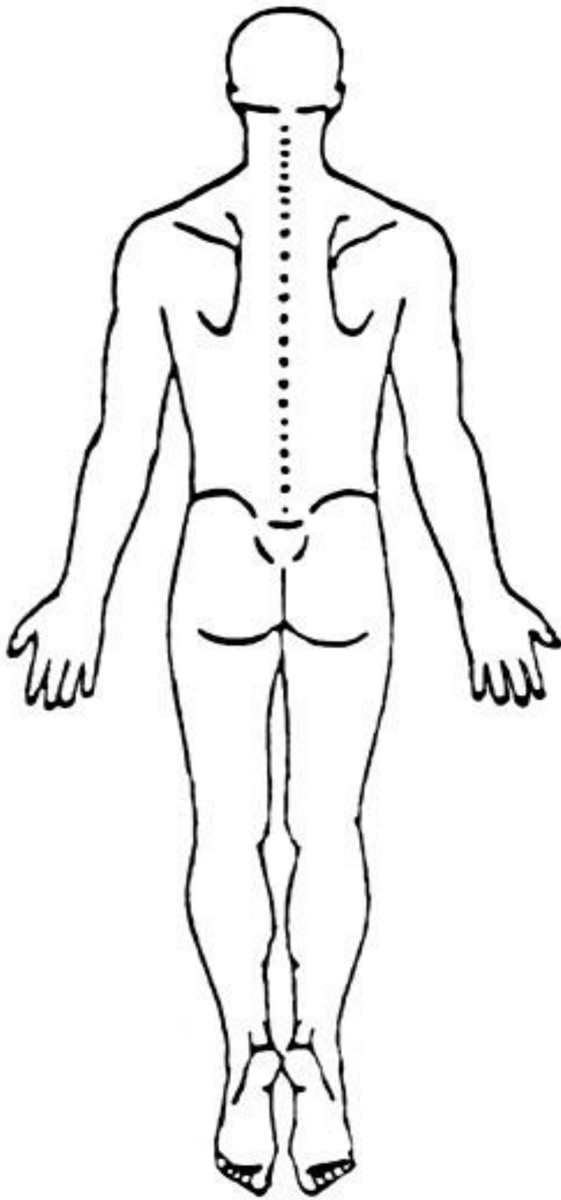
Surgical History

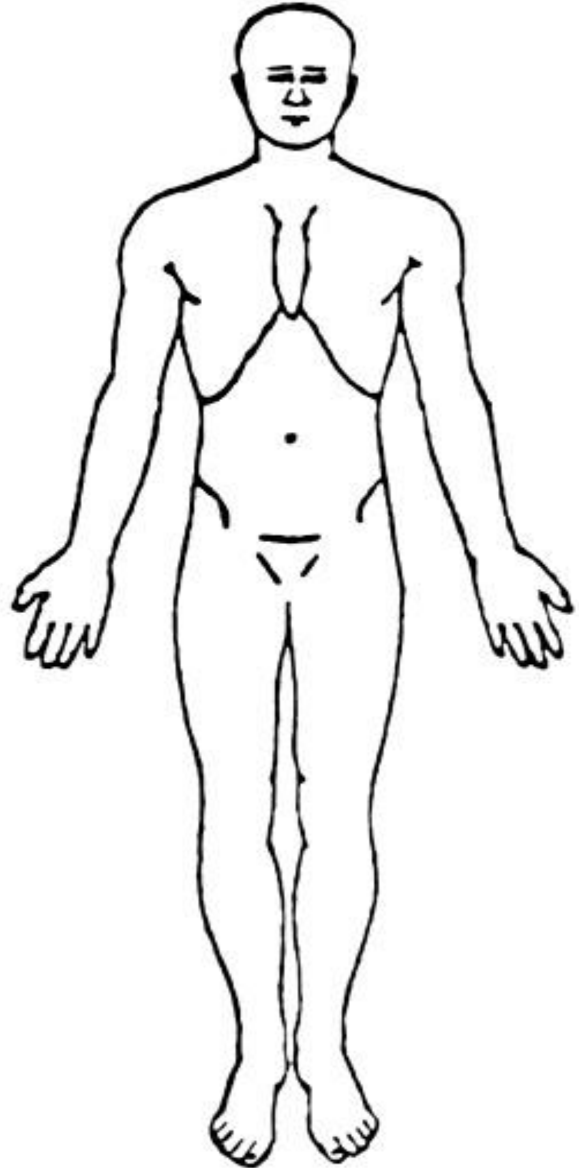
Please list all surgeries:	Date surgery was performed?
1.	
2.	
3.	
4.	
5.	
6.	
7.	

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: ______ / ______ / ______