

The University of Oklahoma-Norman Campus
Workers' Compensation

Medical Questionnaire

Employee Name: _____

Have you ever injured this/these body parts before-on or off the job? If so, please list the body part(s), when injured, and how injured: _____

Name, address and phone of Primary Care Physician: _____

Have you seen a chiropractor in the past? No Yes (please circle) If yes, please list all chiropractor names, address, and telephone number:

List all doctors, including address and telephone number for all doctors you have seen in the past five (5) years:

(Attach sheet if additional space is needed)