

EMPLOYEE PRINTED NAME: \_\_\_\_\_ CLIENT: \_\_\_\_\_

**EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE  
FOR THE SECOND INJURY FUND**

*This information is requested to identify those employees who may qualify for Louisiana's Second Injury Fund. Please complete the entire questionnaire. Please answer the following questions by circling either Yes or No.*

**FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN FORFEITURE OF  
YOUR WORKERS' COMPENSATION BENEFITS, INCLUDING MEDICAL  
TREATMENT AND EXPENSES, UNDER LA. R.S. 23:1208.1.**

1. Have you ever had a disease or disability arising from your occupation: Yes No

If YES, please explain:

---

---

2. Have you ever received workers' compensation benefits for an injury that occurred at work: Yes No

If YES, when? \_\_\_\_\_

How long were you on compensation? \_\_\_\_\_

Name of employer: \_\_\_\_\_

Nature of injury: \_\_\_\_\_

3. Have you ever been rejected for employment, insurance, or military service because of your health? Yes No

If YES, please explain:

---

---

4. Have you ever had back trouble or injury to your back, head or neck? Yes No

If YES, please explain:

---

---

5. Have you ever had any restrictions or limitations upon your physical activities? Yes No

If YES, please explain:

---

---

6. What operations, accidents, broken bones, strains or serious illnesses have you had?

---

---

Have you had any of the following? Put an (x) for Yes and leave blank for No:

<input type="checkbox"/>	Amputation (foot, leg, arm, hand or total loss thereof)	<input type="checkbox"/>	Mental Disorders
<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	Ankylosis of joints
<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Arteriosclerosis
<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Numbness of Extremities	<input type="checkbox"/>	Back/Neck Problem
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Brain Damage
<input type="checkbox"/>	Cardiac Disease	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	Psychoneurotic Disability (following treatment in a recognized institution)
<input type="checkbox"/>	Cerebral Vascular accident	<input type="checkbox"/>	Repetitive Motion Injury
<input type="checkbox"/>	Residual Disability from Polio	<input type="checkbox"/>	Chronic Headaches
<input type="checkbox"/>	Communicable Disease	<input type="checkbox"/>	Chronic Osteomyelitis
<input type="checkbox"/>	Compressed Air Sequelae Disc	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	Silicosis	<input type="checkbox"/>	Ruptured Intervertebral
<input type="checkbox"/>	Spinal Fusion	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Sugar in Urine	<input type="checkbox"/>	Heart Condition
<input type="checkbox"/>	Surgical Removal of Intervertebral Disc	<input type="checkbox"/>	Heavy Metal Poisoning
<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	"Trick" Knee or Shoulder	<input type="checkbox"/>	Thrombophlebitis
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Thyroid Condition
<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Hodgkin's Disease
<input type="checkbox"/>	Ionizing Radiation Injury	<input type="checkbox"/>	Hyperinsulinism
<input type="checkbox"/>	Loss of Hearing (more than seventy-five percent)	<input type="checkbox"/>	Kidney Disorder
<input type="checkbox"/>	Loss of Use of Limbs	<input type="checkbox"/>	Loss of Sight (or one or both eyes or a partial loss of uncorrected vision)

If YES, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Do you or have you had any other adverse physical condition or condition resulting in a partial disability or impairment? Yes No

If YES, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_