

## **SECOND INJURY FUND • Employee Medical History Questionnaire Letter**

We are committed to providing workers' compensation benefits to all employees who sustain an employment-related injury in accordance with Louisiana law.

If a work-related injury or disability is caused, or made worse, by a "pre-existing" condition, (company name) may be able to seek partial reimbursement of the benefit dollars paid to you, or on your behalf, from the Louisiana Second Injury Fund. Such reimbursement would be made to (company name) without a reduction in benefits to you.

In order for (company name) to be considered for reimbursement from the Second Injury Fund, it has to show that it knowingly hired or knowingly retained the employee with a pre-existing disability. To establish this fact, (company name) requires all employees to complete the attached questionnaire.

All questions must be answered. If the answer is "no" or "none," please indicate. All responses must be complete. If a response requires explanation, please provide one. If there is not enough space on the form for a complete response, please complete your response on the back of the form.

The information obtained from the questionnaire will be kept CONFIDENTIAL and will not be made a part of your personnel file. As you complete the attached questionnaire, you should be aware that:

### **FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.**

I have read the foregoing notice and have completed the attached questionnaire to the best of my knowledge, information and belief.

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

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

# SECOND INJURY FUND • Employee Medical History 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 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. Do you have 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" in the appropriate box. Each illness/injury requires a YES (Y) or NO (N) response.

- |   |   |   |   |
|---|---|---|---|
| Y N   | Y N   | Y N   | Y N   |
| <input type="checkbox"/> <input type="checkbox"/> Amputation (foot, leg, arm, hand or total loss thereof) | <input type="checkbox"/> <input type="checkbox"/> Communicable Disease          | <input type="checkbox"/> <input type="checkbox"/> Ionizing Radiation Injury   | <input type="checkbox"/> <input type="checkbox"/> Reflex Sympathetic Dystrophy            |
| <input type="checkbox"/> <input type="checkbox"/> Ankylosis of Joints                                     | <input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae       | <input type="checkbox"/> <input type="checkbox"/> Kidney Disorder   | <input type="checkbox"/> <input type="checkbox"/> Repetitive Motion Injury                |
| <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis  | <input type="checkbox"/> <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> <input type="checkbox"/> Loss of Hearing (more than 75%)   | <input type="checkbox"/> <input type="checkbox"/> Residual Disability from Polio          |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis   | <input type="checkbox"/> <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> <input type="checkbox"/> Loss of Sight (of one or both eyes or a partial loss of uncorrected vision) | <input type="checkbox"/> <input type="checkbox"/> Rheumatism                              |
| <input type="checkbox"/> <input type="checkbox"/> Asthma  | <input type="checkbox"/> <input type="checkbox"/> Double Vision (Blurred Sight) | <input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limbs  | <input type="checkbox"/> <input type="checkbox"/> Rotator Cuff Injury                     |
| <input type="checkbox"/> <input type="checkbox"/> Back/Neck Problem                                       | <input type="checkbox"/> <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> <input type="checkbox"/> Mental Disorders  | <input type="checkbox"/> <input type="checkbox"/> Ruptured Intervertebral Disc            |
| <input type="checkbox"/> <input type="checkbox"/> Brain Damage  | <input type="checkbox"/> <input type="checkbox"/> Epilepsy                      | <input type="checkbox"/> <input type="checkbox"/> Mental Retardation  | <input type="checkbox"/> <input type="checkbox"/> Silicosis                               |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> <input type="checkbox"/> Head Injury                   | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> <input type="checkbox"/> Spinal Fusion                           |
| <input type="checkbox"/> <input type="checkbox"/> Cancer  | <input type="checkbox"/> <input type="checkbox"/> Heart Condition               | <input type="checkbox"/> <input type="checkbox"/> Muscle, Ligament or Tendon Injury   | <input type="checkbox"/> <input type="checkbox"/> Stroke                                  |
| <input type="checkbox"/> <input type="checkbox"/> Cardiac Disease   | <input type="checkbox"/> <input type="checkbox"/> Heavy Metal Poisoning         | <input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> <input type="checkbox"/> Sugar in Urine                          |
| <input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome                                  | <input type="checkbox"/> <input type="checkbox"/> Hemophilia                    | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> <input type="checkbox"/> Surgical Removal of Intervertebral Disc |
| <input type="checkbox"/> <input type="checkbox"/> Cerebral Vascular Accident                              | <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure       | <input type="checkbox"/> <input type="checkbox"/> Numbness of Extremities   | <input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis                        |
| <input type="checkbox"/> <input type="checkbox"/> Chronic Headaches                                       | <input type="checkbox"/> <input type="checkbox"/> Hodgkin's Disease             | <input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease   | <input type="checkbox"/> <input type="checkbox"/> Thoracic Outlet Syndrome                |
| <input type="checkbox"/> <input type="checkbox"/> Chronic Osteomyelitis                                   | <input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism               | <input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability (following treatment in a recognized institution) |   |
|   | <input type="checkbox"/> <input type="checkbox"/> Hypertension                  |   |   |

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

7. Do you have any other long-term health problems or adverse physical conditions? YES NO  
If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

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

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