INJURY QUESTIONNAIRE

Name:__________________________________________________________

NATURE OF ACCIDENT:

1. Date of accident:_________________  Time of Day:______________

2. Where did the accident occur:__________________________________

3. In your own words, please describe the accident:__________________

4. Please describe how you felt:
   IMMEDIATELY AFTER the accident:______________________________
   LATER THAT DAY:___________________________________________
   THE NEXT DAY:__________________________________________

5. Where were you taken after the accident?________________________

6. What are your PRESENT complaints and symptoms?________________

__________________________________________

Form-AM-10
7. Have you been treated by another doctor since the accident? ( ) Yes  ( ) No
   If yes, please list doctor’s name and address: ________________________________

8. What type of treatment did you receive? ________________________________

9. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
   If yes, please describe in detail: ________________________________

10. Did you have any physical complaints BEFORE THE ACCIDENT?
    ( ) Yes ( ) No If yes, please describe in detail: ________________________________

11. Have you ever been in an accident before? ( ) Yes ( ) No If yes please
    describe in detail: ________________________________

12. Are you taking any medications? ( ) Yes ( ) No If yes, please list:
    ________________________________

13. Are you allergic to any medications? ( ) Yes ( ) No If yes, please list:
    ________________________________

Date  Patient’s signature
# FAMILY MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Family</th>
<th>√ If Alive</th>
<th>Age at Death</th>
<th>Present Health or Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Brothers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**SOCIAL HISTORY:**
- ( ) Smoke Cigarettes  
  If so, how many per day ____________
- ( ) Drink alcohol  
  If so, how many per day ____________

Have you had any of the following? If so, please check all that apply.

**EYES:**
- ( ) Glasses  
- ( ) Visual loss  
- ( ) Blurry vision  
- ( ) Glaucoma  
- ( ) Cataracts

**EARS, NOSE, MOUTH AND THROAT:**
- ( ) Hearing loss  
- ( ) Ringing in ears  
- ( ) Dizziness  
- ( ) Nosebleeds  
- ( ) Hoarseness  
- ( ) Sinus Infection  
- ( ) Rhinitis  
- ( ) Dentures  
- ( ) Difficulty swallowing

**CARDIOVASCULAR:**
- ( ) Chest pain  
- ( ) Irregular heartbeat  
- ( ) Heart attack  
- ( ) Heart murmur  
- ( ) High Blood Pressure  
- ( ) Rheumatic fever

**RESPIRATORY:**
- ( ) Shortness of breath  
- ( ) Wheezing  
- ( ) Coughing up blood  
- ( ) Asthma  
- ( ) Pneumonia

**GASTROINTESTINAL:**
- ( ) Loss of appetite  
- ( ) Vomiting  
- ( ) Abdominal pain  
- ( ) Diarrhea  
- ( ) Constipation  
- ( ) Ulcers  
- ( ) Hemorrhoids  
- ( ) Bloody stools  
- ( ) Hepatitis  
- ( ) Cirrhosis  
- ( ) Irritable bowel syndrome

**GENITOURINARY:**
- ( ) Burning of urination  
- ( ) Frequency of urination  
- ( ) Blood in urine  
- ( ) Pain on urination  
- ( ) Kidney stones  
- ( ) Prostate problems

**MUSCULOSKELETAL:**
- ( ) Muscle or joint pain  
- ( ) Joint swelling  
- ( ) Disc herniation  
- ( ) Arthritis  
- ( ) Atrophy  
- ( ) Ligament injury  
- ( ) Weakness

**INTEGUMENTARY:**
- ( ) Rash  
- ( ) Itching  
- ( ) Bruising  
- ( ) Cancer  
- ( ) Lesions  
- ( ) Hair loss  
- ( ) Ulcers  
- ( ) Moles
<table>
<thead>
<tr>
<th>Category</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological</td>
<td>( ) Seizure disorder ( ) tremor ( ) numbness ( ) Speech problems ( ) Loss of consciousness ( ) Changes in smell, hearing or taste ( ) Severe headaches</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>( ) Mood swings ( ) Anxiety ( ) Depression ( ) Fears ( ) Sleep disturbances ( ) Panic attacks ( ) Phobias</td>
</tr>
<tr>
<td>Endocrine</td>
<td>( ) Diabetes ( ) Thyroid disease ( ) Excessive thirst ( ) Sensitivity to cold and heat</td>
</tr>
<tr>
<td>Hematological/Lymphatic</td>
<td>( ) Bleeding ( ) Easy bruising ( ) Fatigue ( ) Enlarged lymph nodes ( ) Blood clots (Anemia)</td>
</tr>
<tr>
<td>Immunological</td>
<td>( ) Allergies ( ) Hay fever ( ) Frequent infections</td>
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