

ACCT: #
FOR OFFICE USE ONLY



PATIENT HISTORY

Today's Date: _____

Patient's Full Name: _____ Birthdate: _____ Age: _____

New Patient: Yes No Est. patients new injury: _____

Referred by Dr. _____

PLEASE READ THIS STATEMENT

Per insurance company requirements, you may be required to fill out an accident/injury report prior to accepting your claim. To prevent a delay in acceptance of the claim or a possible denial, please fill out this form and sign it below. Without a signature your insurance company will not accept this form and you may subsequently be billed if your insurance denies payment.

If the problem you are being seen for was not from an accident please state time of onset and a brief statement explaining your problem.

Problem you are being seen for: _____

Date of onset or injury: _____

Work Injury Auto Accident Sports Injury Other: _____

Where did the injury/problem occur?: _____

Describe how the problem began: _____

Were you taken to an emergency room?: Yes No If Yes, which one?: _____

Were you taken by ambulance?: Yes No If No, how long after injury?: _____

By what mode of transportation?: _____

You were seen in the ER for what symptoms?: _____

X-rays taken of: _____ Were you casted/splinted/braced?: Yes No

Were other tests performed?: Yes No If Yes, what?: _____

If you did not go to the ER, where did you first go?: _____

Patient Signature

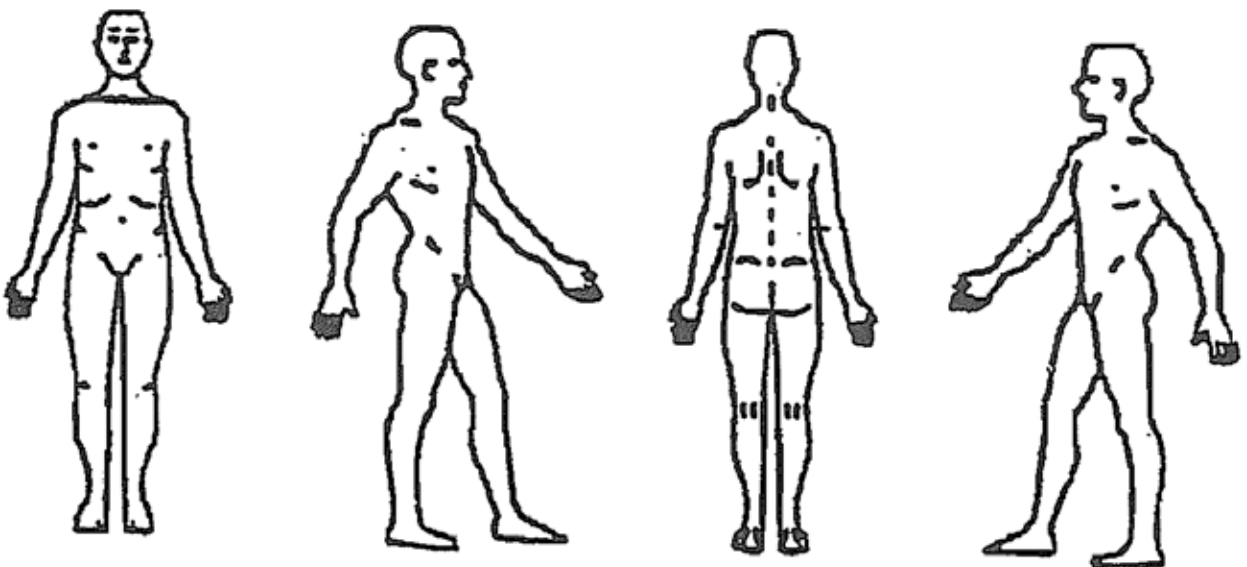
Date

Describe any symptoms on the appropriate line.

Example: AFTER THE ACCIDENT: sharp, constant. NOW: dull and throbbing, comes and goes

SYMPTOMS EXPERIENCED	AFTER THE ACCIDENT	NOW
Headaches	_____	_____
Vision Problems	_____	_____
Dizziness	_____	_____
Memory Problems	_____	_____
Loss of Coordination	_____	_____
Sleep Disorders	_____	_____
Anxiety	_____	_____
Depression	_____	_____
Mood Swings	_____	_____
Numbness (where)	_____	_____
Pain (where)	_____	_____
Other	_____	_____
Other	_____	_____
Other	_____	_____

Indicate with an X the areas of your body injured:



PAST MEDICAL HISTORY

Check Yes or No if you have had any of the following:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension (high blood pressure):	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma / breathing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcers / stomach pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation / diarrhea (for unknown reasons)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Migraine headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression / other mental disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fracture / dislocation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

If other please indicate: _____

Check Yes or No if any member of your immediate family has had any of the following:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension (high blood pressure):	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No

List all surgeries and the year they were done:

Year: _____ Surgery: _____

Year: _____ Surgery: _____

Year: _____ Surgery: _____

What medications are you taking and which doctor prescribed it for you?:

Doctor: _____ Medication: _____

Doctor: _____ Medication: _____

Doctor: _____ Medication: _____

List any allergies to drugs and your reaction to it:

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Do you smoke?: Yes No

If Yes, how many packs a day?: _____

Do you use other tobacco products?: Yes No

Do you drink alcohol?: Yes No

How much per day?: _____

MEN ONLY

When was your last prostate exam? _____

Was it normal?: Yes No

When was your last hernia exam? _____

Was it normal?: Yes No

WOMEN ONLY

When was your last pap exam?: _____

Was it normal?: Yes No

Are your menstrual periods regular?: Yes No

If not did they become irregular after the injury?: Yes No

Are you postmenopausal?: Yes No

Have you had a tubal ligation?: Yes No Year?: _____

Hysterectomy?: Yes No Year?: _____

Are you on estrogen replacement?: Yes No