

Health History

Last Name: _____ First Name: _____ MI: _____

Present Complaints

1. _____
2. _____
3. _____
4. _____

How did it Start? _____

Other doctors seen for this problem: _____

Medications currently taking: _____

Allergies to Meds/Foods: _____

Women Only: Are you pregnant: Y/N Are you taking birth control? Y/N

*I hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time: **Signature:** _____*

Accident/Injury History

Were you a () Driver () Passenger () front or () back ? Wearing a seat belt? Y/N

Were you struck from: () Behind () Front () Left Side () Right Side

Were you prepared for the impact? Y/N Were the police notified? Y/N

Were you knocked unconscious? Y/N Did EMS render any aid? Y/N

Describe how you felt following the accident:

Did you go to the hospital? Where? What was done?

Have you been treated by another doctor for this injury? Y/N

If yes, what have you had done? _____

What type of work do you do? _____

Have you missed any time from work? Y/N How much? _____

What restrictions do you have due to the injury?

Signature: _____ **Date:** _____