HEALTH SURVEY

Please describe your injuries and symptoms resulting from this accident:

____

____

____

____

____

____

What medication(s) did you take? ______________________________

Are you still taking medication(s)? ☐ Yes ☐ No

If yes, how often and how much? ______________________________

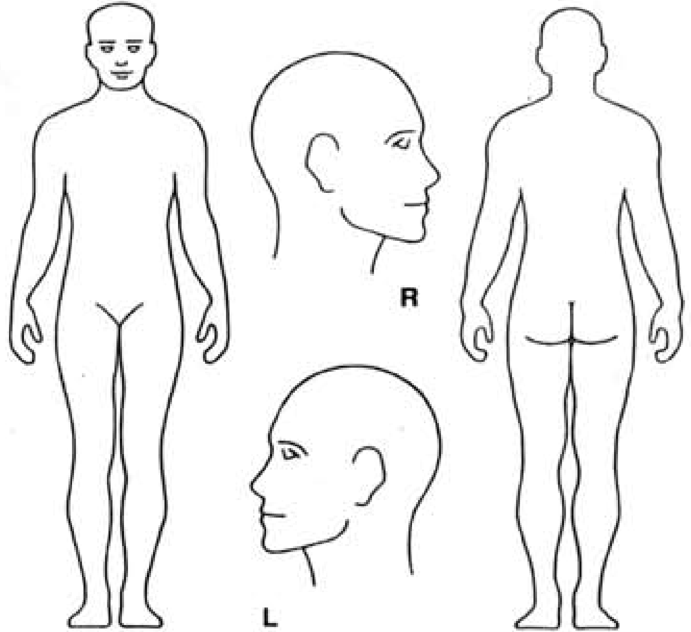
Did you return to work? ☐ Yes ☐ No

If no, how long were you off work? ______________________________

If yes, were there any restrictions or limitations? ______________________________

____

Mark areas of pain resulting from this accident on figures below:



Please mark the degree of all conditions which you have, or have had. Use the following letters to rate your conditions:

O = Occasional
F = Frequent
C = Constant

GASTRO-INTESTINAL

_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Diarrhea
_____ Constipation
_____ Bloody stool
_____ Black stool
_____ Hemorrhoids
_____ Weight trouble
_____ Liver trouble
_____ Gall bladder trouble

NERVOUS SYSTEM

_____ Dizziness
_____ Fainting
_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Headaches
_____ Convulsions
_____ Muscle spasms
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR

_____ Chest pain
_____ Rapid heartbeat
_____ Heart problems
_____ Pain over heart
_____ Blood pressure problems
_____ Varicose veins
_____ Lung problems
_____ Coughing phlegm
_____ Coughing blood
_____ Persistant cough
_____ Difficult breathing

EYE, EAR, NOSE & THROAT

_____ Eye strain
_____ Vision problems
_____ Eye infection
_____ Hearing loss
_____ Ear noises
_____ Ear pain
_____ Ear discharge
_____ Nose bleeding
_____ Nose discharge
_____ Nose pain
_____ Difficult nose breathing
_____ Difficult speech
_____ Dental problems
_____ Sore gums
_____ Sore mouth
_____ Sore throat
_____ Hoarseness

GENITO-URINARY

_____ Bladder trouble
_____ Painful urination
_____ Discolored urine
_____ Scanty urination
_____ Excessive urination

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?

☐ Yes ☐ No

MUSCULO-SKELETAL

_____ Low back problems
_____ Neck problems
_____ Pain between shoulders
_____ Arm problems
_____ Leg problems
_____ Painful joints
_____ Stiff joints
_____ Swollen joints
_____ Sore muscles
_____ Weak muscles
_____ Broken bones
_____ Ruptures
_____ Walking problems

Patient's Signature:
(If a minor, parent's or guardian's signature) ______________________________ Date: ______________

Doctor's Signature: ______________________________ Date: ______________