

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

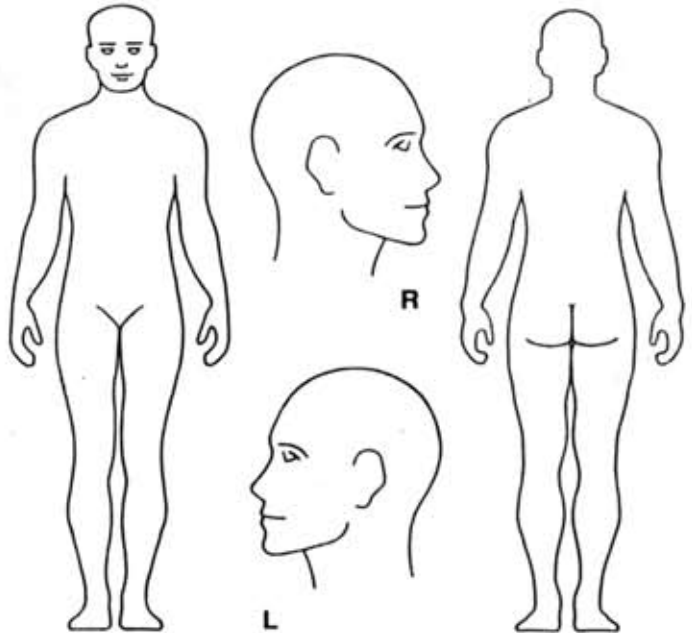
If yes, how often and how much?

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

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
- Persistent 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

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

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

Date: _____

Doctor's Signature: _____

Date: _____