AUTO ACCIDENT MEDICAL PROFILE

Today's Date_____

Name (Last)_____ **(First)**_____**(M.I.)**_____

Where did you feel pain?_____

What are your symptoms?_____

Name of any other Doctors consulted since your accident_____

_____

Treatment received_____

How often did you receive care from other Doctors?_____

Have you previously been injured in a similar manner?_____

If so, explain_____

Please list all hereditary/congenital medical conditions_____

Please list all surgeries/operations and dates_____

Name of all medications and dosage you are currently taking _____

_____

Do you smoke?_____ **Number per day**_____

Weekly alcohol consumption_____ **Daily water consumption**_____

Please explain in detail how your accident happened _____

_____

_____

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