

What surgery has been done? _____

Are you pregnant? Yes No
Drugs you now take: Nerve Pills Pain Killers Muscle Relaxers "Pep" Pills Tranquilizers Insulin
 Birth Control Pills Other (please list) _____

<p>Do you experience any of the following:</p> <p><input type="checkbox"/> Shortness of breath <input type="checkbox"/> Fatigue & Weakness <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Heart Palpitations or Murmurs <input type="checkbox"/> Swelling <input type="checkbox"/> Difficulty Breathing</p> <p>Have you ever been diagnosed with any of the following:</p> <p><input type="checkbox"/> Aortic, Tricuspid or Mitral Valve Disorder</p> <p><input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Myocardial Ischemia/Infarction <input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Arrhythmias <input type="checkbox"/> Heart Failure <input type="checkbox"/> Coronary Artery Disease</p> <p><input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Infectious Endocarditis</p> <p>Do you experience:</p> <p><input type="checkbox"/> Dizziness <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Ringing/Buzzing in Ears</p> <p><input type="checkbox"/> Double/Blurred Vision <input type="checkbox"/> Sensitivity to light/sound</p> <p><input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Loss of balance</p> <p><input type="checkbox"/> Numbness/Loss of sensation in legs <input type="checkbox"/> Trouble walking</p> <p><input type="checkbox"/> Trouble getting out of bed/chair</p>

Patient's Signature _____ Social Security Number _____ Date _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: _____ Hour: _____ A.M. P.M. Location: _____

How did accident occur? Auto Collision On-the-job injury* Other _____

*If on-the-job injury, are you still employed by the company? Yes No

Please describe the circumstances: _____

List the extent of the injuries as you know them: _____

Did you require post-accident hospitalization? Yes No If yes, name of Hospital _____

Other prior medical treatment received for injury from the accident: _____

Date	Name of Doctor	Place of Treatment	Phone Number

- Check symptoms you have noticed since accident:
- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Have you lost any days of work? Yes No Dates: _____

Name of your insurance company involved: _____

Name of insurance company of person/work place responsible for injuries: _____

Have you been contacted by an insurance adjuster of company representative regarding this claim? Yes No

Do you have an attorney who has advised you in this case? Yes No Name: _____

Address of attorney: _____ Phone Number: _____