A+ Rehab Medical Center
1793 W. Hillsborough Ave.
Tampa, FL 33603
Ph: 813-876-7373 • Fax: 813-876-7375

INJURY QUESTIONNAIRE

Name: _____

NATURE OF ACCIDENT:

Date of accident: _____ **Time of Day:** _____

Where did the accident occur? _____

In your own words, describe the accident:

_____
_____
_____
_____

Please describe how you felt

IMMEDIATELY AFTER the accident: _____
LATER THAT DAY: _____
THE NEXT DAY: _____

Where were you taken after the accident? _____

What are your PRESENT complaints and symptoms?

_____
_____
_____
_____

Have you been treated by another doctor since the accident: ( ) Yes ( ) No
If yes, please list doctors name and address:

_____

What type of treatment did you receive?

_____

_____

_____

Do you notice any activity restrictions as a result of this injury?
( ) Yes ( ) No
If yes, please describe in detail:

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT?
( ) Yes ( ) No
If yes, please describe in detail:

_____

_____

_____

Have you ever been in an accident before? ( ) Yes ( ) No
If yes, please describe in detail:

_____

_____

_____

Are you taking any medications? ( ) Yes ( ) No If yes, please list:

_____

_____

Are you allergic to any medications? ( ) Yes ( ) No If yes, please list:

_____

_____ _____

Date **Patient's signature**

FAMILY MEDICAL HISTORY

Family	√ If Alive	Age at Death	Present Health or Cause of Death
Father			
Mother			
Brothers			
Sisters			

SOCIAL HISTORY: ( ) Smoke Cigarettes If so, how many per day _____
( ) Drink alcohol If so, how many per day _____

Have you had any of the following? If so, please check all that apply.

EYES: ( ) Glasses ( ) Visual loss ( ) Blurry vision ( ) Glaucoma ( ) Cataracts

EARS, NOSE, MOUTH AND THROAT: ( ) Hearing loss ( ) Ringing in ears
( ) Dizziness ( ) Nosebleeds
( ) Hoarseness ( ) Sinus infection
( ) Rhinitis ( ) Dentures
( ) Difficulty swallowing

CARDIOVASCULAR: ( ) Heart attack ( ) Heart murmur
( ) High Blood Pressure ( ) Rheumatic fever

RESPIRATORY: ( ) Shortness of breath ( ) Wheezing ( ) Asthma
( ) Coughing up blood ( ) Pneumonia

GASTROINTESTINAL: ( ) Loss of appetite () Vomiting ( ) Abdominal pain ( ) Diarrhea ( ) Constipation ( ) Ulcers
( ) Hemorrhoids ( ) Bloody stools ( ) Hepatitis
( ) Cirrhosis ( ) Irritable bowel syndrome

GENITOURINARY: ( ) Burning of urination ( ) Frequency of urination
( ) Blood in urine ( ) Pain on urination
( ) Kidney stones ( ) Prostate problems

MUSCULOSKELETAL: ( ) Muscle or joint pain ( ) Joint swelling
( ) Disc herniation ( ) Arthritis ( ) Atrophy
( ) Ligament injury ( ) Weakness

INTEGUMENTARY: ( ) Rash ( ) Itching ( ) Bruising ( ) Cancer
( ) Lesions ( ) Hair loss ( ) Ulcers ( ) Moles

NEUROLOGICAL:	( ) Seizure disorder ( ) tremor ( ) numbness ( ) Speech problems ( ) Loss of consciousness ( ) Changes in smell, hearing or taste ( ) Severe headaches
PSYCHIATRIC:	( ) Mood swings ( ) Anxiety ( ) Depression ( ) Fears ( ) Sleep disturbances ( ) Panic attacks ( ) Phobias
ENDOCRINE:	( ) Diabetes ( ) Thyroid disease ( ) Excessive thirst ( ) Sensitivity to cold and heat
HEMATOLOGICAL/ LYMPATHIC:	( ) Bleeding ( ) Easy bruising ( ) Fatigue ( ) Enlarged lymph nodes ( ) Blood clots ( ) Anemia
IMMUNOLOGICAL:	( ) Allergies ( ) Hay fever ( ) Frequent infections