Dr. Nate Greenstein
Patient Accident Health History (1 of 2)

Please complete both pages of the accident health history form. Be as complete and accurate as possible. If something does not apply, record the word **"none"** for that item**. Please print or type.**

Name: _____ Date: _____

Date of accident: _____ Time: _____ AM ; PM (circle one)

Location: _____

Type of accident: Auto On-The-Job Other (circle appropriate responses)

If other, explain: _____

Have you lost any days of work? No Yes (circle one)

If yes, give dates: _____

If automobile accident, complete the following:

Were you: Driver Passenger Pedestrian (circle one)
Were you wearing a seat belt? Yes No (circle one)
Were you struck from: Behind Front Right side Left side (circle appropriate responses)
Were traffic citations issued to you, the driver of your car and/or the driver of the other car? Yes No (circle one)
If yes, explain: _____

Explain how the accident occurred: _____

If an on-the-job accident, complete the following:

Did you report the injury to the employer? Yes No (circle one)
Did your employer recommend you to Dr. Greenstein's office? Yes No (circle one)
Explain how the accident occurred: _____

If not an automobile or on-the-job accident, complete the following:

Explain how the accident occurred: _____

Were you hospitalized? Yes No (circle one)
If yes, explain: _____

List your current problems in order of importance, describing each one in detail as to its location, nature and occurrence.

List any other problems you have experienced that are no longer present. _____

List any problems you had before the accident and explain how this accident has affected them. _____

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List all measures taken to-date to improve your problems including physician(s) seen, diagnostic tests performed, recommendations made and treatments rendered.

Explain how your injuries have changed (modified) your actions and the way you live.

List and give the dosage of all prescription and non-prescription medications you are currently taking, when you started them, the reason for them and the results.

List the nutritional supplements you are currently taking, including the brand name, content and potency. Indicate the frequency which they are taken.

List any signs and/or symptoms you may be experiencing or have experienced in each of the body systems.

Constitutional Symptoms (i.e. fever, weight loss)
Eyes
Ears, Nose, Mouth & Throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Integumentary (skin and/or breast)
Neurological
Psychiatric
Endocrine (i.e. thyroid, adrenals)
Blood/Lymphatic
Allergic/Immunologic

Concerning your past history, list, briefly describe, and give dates of **any** past accident, injury, illness, sickness, surgery, and dental work.

List and explain your family health history for all current and past significant health problems.(e.g.Heart disease, cancer)

Please read, sign and date the following:

I completed this health history to the best of my knowledge. It is considered up-to- date, factual and an accurate representation of my health. I will notify you of any future changes with my health history.

Patient/Legal Guardian: Date: