

Date: \_\_\_\_\_

**PATIENT HISTORY**

Physician \_\_\_\_\_

**NO-FAULT**

***Enrique Ergas, MD & Thomas Youm, MD***

Name _____	Employer _____
Address _____	Address _____
Phone(H) _____	DOB _____
(W) _____	Age _____
Insurance _____	SS# _____
Policy# _____	Requesting Doctor: _____
File# _____	Address _____
Policy Holder: _____	Phone _____
	Other Referral: _____

Initial Visit Date _____	Occupation _____
Age _____	Height _____
Eyes _____	Hair _____
Sex: M F	
Weight _____	Handed: R L
Race: W B	Asian Hisp

***History Present Illness (what happened?)***      ***Date of Accident:*** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Location of accident: \_\_\_\_\_

Driver: YES NO      Passenger: FRONT SEAT      BACK SEAT      PEDESTRIAN

Car was struck in: FRONT      BACK      DRIVER SIDE      PASSENGER SIDE

By: CAR TRUNK VAN BUS OTHER \_\_\_\_\_

Was taken to: Hospital Name \_\_\_\_\_ When \_\_\_\_\_

Xrays taken: YES NO      AREA: \_\_\_\_\_

By: AMBULANCE      CAR      WALK

Hospitalized: YES NO      How long \_\_\_\_\_      ER Only \_\_\_\_\_

Lost Consciousness: YES NO      How Long \_\_\_\_\_

***Injuries Suffered:***

*Head:*      Headaches      Dizziness      Nausea      Vomiting      Blurred Vision

*Neck* \_\_\_\_\_      *Upper Back* \_\_\_\_\_      *Lower Back* \_\_\_\_\_      *Chest* \_\_\_\_\_

*Upper Extremities:*      Collar Bone R L;      Shoulder R L;      Upper Arm R L

Elbow R L;      Forearm R L;      Wrist R L;      Hand R L

*Lower Extremities:*

Hip R L;      Thigh R L;      Knee R L;      Leg R L;      Ankle R L;      Foot R L

What are your complaints now: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What other doctors have you seen: \_\_\_\_\_  
\_\_\_\_\_

Any other accident or operation (even if not related) YES NO  
What and when: \_\_\_\_\_  
\_\_\_\_\_

What treatments have you tried? Nothing\_\_ Medications(specify)\_\_\_\_\_  
PT\_\_\_\_ Injections(specify)\_\_\_\_\_ Other\_\_\_\_\_  
Improvement with treatment? Which? \_\_\_\_\_  
Studies? Xrays \_\_\_\_\_ MRI \_\_\_\_\_ CT Scan \_\_\_\_\_ EMG \_\_\_\_\_ Other\_\_\_\_\_  
(When? Results?)\_\_\_\_\_

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**Review of Systems:** Have you had any of the following recently?

Fever or Chills\_\_\_\_\_ Blurred Vision\_\_\_\_\_ Shortness of Breath\_\_\_\_\_ Sore Throat\_\_\_\_\_  
Chest Pain\_\_\_\_\_ Nausea\_\_\_\_\_ Painful Urination\_\_\_\_\_ Rashes\_\_\_\_\_ Headaches\_\_\_\_\_  
If so, explain:\_\_\_\_\_

**Allergies**\_\_\_\_\_ **Tolerate NSAIDs?** \_\_\_\_\_

**Social Hx:** Tobacco\_\_ Alcohol\_\_ Drugs\_\_ **Pregnant:** Y N **Marital Status:** S M D W

**Family History:** DIABETES HEART DISEASE CANCER HYPERTENSION STROKE

If parent(s) deceased, underlying condition? Mother\_\_\_\_\_ Father\_\_\_\_\_

**Medical Hx:** HEART LUNGS STOMACH LIVER KIDNEY BLADDER DIABETES HTN

Explain:\_\_\_\_\_

**Prior Surgeries**\_\_\_\_\_

**Medications**\_\_\_\_\_

**Are you taking blood thinners:** COUMADIN ASPIRIN PLAVIX \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_