Scott M. Taylor, M.D.
A Professional Corporation
400-29th Street, Suite 400
Oakland CA 94609

PERSONAL INJURY HISTORY

Name:____ Age: ____ Today's Date:_______

Date of Injury: ___________ Time of Injury: ___________ RHD or LHD

Place of accident: ____ Wt: _________ Ht: ______

What Body parts were injured (please be specific): ____

____

____

____

How did the injury happen (please be specific): ____

____

____

____

____

Were you the driver? _______ If not who was the driver: _____________________________________

Were you wearing seat belts? ____ Were you seen in the emergency room? ___ If yes, what emergency room and when? ____

Were x-rays taken___ If yes, what body parts were x-rayed? ________________________________

What medical treatment have you received and by whom? ___________________________________

____

____

____

PAST MEDICAL HISTORY

Allergies and reaction: ____

____

Medications you are taking: ____

____

Major illnesses (i.e. high blood pressure, asthma, diabetes, etc.): _____________________________

____

Patient's Name: ___________________________

Operations: ____

____

Accidents/Broken bones: ____

____

Previous work related injuries: ____

____

____

WORK HISTORY

Employer: ____

Job Title and duties: ____

____

____

____

____

Did you miss any work due to this injury: _____ If yes, date you last worked ____________________

NOTES