

MEDICAL QUESTIONNAIRE

Please print this document and bring it with you to your doctor's appointments. This document is for you to fill out, not your doctor. Please make notes in all of the spaces on this form. Please be advised that this document is confidential, work product created in conjunction with an attorney in anticipation of litigation. DO NOT DISCLOSE this document to anyone other than your attorney

DOCTOR'S NAME: _____

SPECIALTY: _____

ADDRESS: _____

PHONE NUMBER: _____

WHAT IS THE MEDICAL NAME FOR MY INJURY?

WERE MY INJURIES CAUSED BY MY ACCIDENT? YES/NO

ARE MY INJURIES PERMANENT? YES/NO

WHAT IS MY PROGNOSIS: _____

WHAT FUTURE MEDICAL TREATMENT WILL I NEED?

HOW MUCH WILL MY FUTURE MEDICAL NEEDS COST? \$ _____

DO I NEED TO SEE A SPECIALIST? YES/NO WHO? _____

WILL YOU REFER ME? _____

WILL YOU BE WILLING TO TESTIFY ON MY BEHALF IN COURT? YES/NO

ARE ANY PREEXISTING MEDICAL PROBLEMS CAUSING MY CURRENT MEDICAL PROBLEMS? YES/NO

IF YES, WHAT ARE THEY AND HOW ARE THEY AFFECTING ME?

CAN MY LAWYER CALL YOU TO SPEAK TO YOU ABOUT MY PROBLEMS? Y / N

WHEN IS THE BEST TIME TO REACH YOU? _____

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