

MOTOR VEHICLE ACCIDENT

Fill out this page for *any* car accident in the patient's past history.

Patient Name:

Describe the accident:

Date or age:

Time:

Location:

Restraint:

Seat belt and airbag

Seat belt only

Harness & Airbag

Shoulder harness only

Unrestrained

Airbag only

Patient's location during the accident:

Drivers seat

Back left

Front Passenger

Back right

Center front

Center back

Other:

Patient's Vehicle

Their Vehicle

Type of Vehicle:

Car

Truck

Other:

Car

Truck

Other:

Primary Impact:

Direct front

Right door panel

Direct front

Right door panel

Front left

Right front quarter

Front left

Right front quarter

Front right

Right rear quarter

Front right

Right rear quarter

Direct rear

Left door panel

Direct rear

Left door panel

Rear left

Left Front quarter

Rear left

Left Front quarter

Rear right

Left rear quarter

Rear right

Left rear quarter

Impact occurred when the other vehicle was:

Stationary

moving parallel to patient's vehicle

moving from left to right

moving from right to left

Other:

Approximate Speed At The Time Of Impact:

1-5 mph

10 mph

15 mph

20 mph

25 mph

30 mph

40 mph

50 mph

60 mph

70 mph or more

Secondary Impact:

Did not occur

Rear vehicle

Included rollover

Front vehicle

Left vehicle

Right vehicle

Location of Trauma:

No observable tissue injury

Top head

Forehead

Back head

Jaw

Jaw joint

Behind ear

Ear

Cheek

Chin

Nose

Lips

Teeth

Tongue

Neck

Eyes

Other:

Symptoms First Noted:

Immediately

Same day

Next day

One week

One month

Six months

One year

Symptoms First Treated:

Immediately

Same day

Next day

One week

One month

Six months

One year

First medical care received at:

by attending ER doctor

private physician

Other:

List symptoms and description of injury: