TRAUMA QUESTIONNAIRE

John R. Droter, D.D.S.
4000 Mitchellville Rd., 330B
Bowie, Maryland, 20716
301-805-9400
drdroter @mac.com

Name _____Date_____

PLEASE ANSWER ALL QUESTIONS

I. Date of Trauma_____

Was your trauma from (circle one)

Auto accident Fight Fall Sports Injury Other

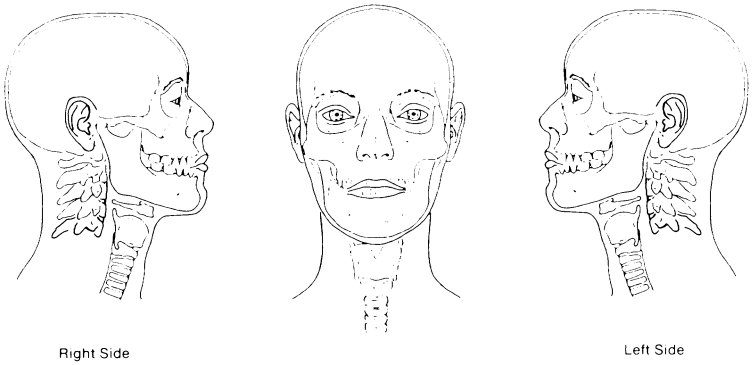
How did the trauma happen?_____

_____

_____

_____

On the diagram below draw an arrow to indicate the location



II. During the trauma, did you strike your (circle all that apply)

Skull Nose Chin Lower jaw Neck Chest

Other_____

Did you have whiplash? Y N

Which of the following did you have as a result of the accident?

Cuts Abrasions Bruises Bleeding from the mouth

Bleeding from the nose Bleeding from the ears

III. Were you knocked out? Y N How long ? _____

What was your first memory after the trauma?_____

_____

IV. Immediately post-trauma, were you treated (circle all that apply)

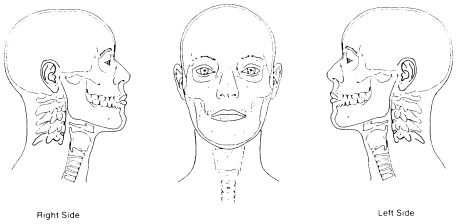
Emergency room Doctor's office Other _____

Name of facility_____

When were you first seen for evaluation after the trauma? _____

Please do not write in this space.

Trauma



V. What Hurt after the trauma? _____

_____

_____

VI. List all doctors who have treated you for this trauma and explain what they had done:

Emergency physician, Family Doctor , Physical therapist, Chiropractor, Dentist, Oral Surgeon, Neurologist, Psychologist

_____

_____

_____

_____

_____

VII. Did you have X-rays of the (circle all that apply)

Face Neck Skull Other_____

Did you have a CT scan? Y N

Did you have a MRI scan? Y N

What other tests did you have?_____

_____

VIII. Who do you feel is at fault for your trauma?_____

_____

Explain_____

_____

IX. Is your pain getting (circle one) Worse Better Unchanged

X. Do you have an attorney representing you? Y N

Your attorney's name_____

XI. I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing.

_____ _____

Signature Date

Please do not write in this space.