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PRELIMINARY MEDICAL MALPRACTICE QUESTIONNAIRE

SECTION 1: PERSONAL DETAILS:

Title: Mr/Ms/Miss/Mrs/Dr/Other-please specify:_____

Name:_____

Date of Birth:_____Marital Status:_____

Nationality:_____: Age at of Time of injury_____

Permanent Address:_____

Seasonal Address:_____

Mobile:_____Home_____Work:_____

Fax:_____Email:_____

Next of Kin/Contact in Case of an Emergency:_____

Phone No:_____ Email:_____

Address:_____

SECTION 2: COMPLAINTS AND INITIAL TREATMENT

Incident/Accident Date:_____Location:_____

Name and Address of Treating Health Care Professional:_____

_____

Name and Address of Treating Health Care Professional:_____

Address of Professional:_____

_____

COMPLAINT(S):

Nature of Complaint:_____

Symptoms:

1._____ 2._____3._____

Date of Onset of Symptoms/Feelings:_____

DIAGNOSIS:

Date First Seen by Professional/Physician_____Time:_____

Initial Treatment/Diagnosis:_____

_____

INITIAL TREATMENT:

Medicines: 1._____2._____

3._____4._____

Other Remedies:_____

Instructions:_____

_____

OUTLOOK/PROGNOSIS:

1._____

2._____

3._____

FOLLOW-UP TREATMENT:

_____

_____

_____

CURRENT CONDITION(s):

1._____2._____

3._____4._____

REMEDIAL TREATMENT SOUGHT:

Date:_____Time:_____Recommended by:_____

Treatment Recommended: _____

_____

SECTION 3- REMEDIAL /SECONDARY TREATMENT

Name of Professional/Facility:_____

Address:_____

_____

Tel:_____Fax:_____

Email:_____ Email 2:_____

NEW DIAGNOSIS:_____

_____

_____

TREATMENT:_____

_____

_____

OUTLOOK/PROGNOSIS:_____

_____

_____

CURRENT CONDITION:_____

_____

_____

OTHER SITUATIONS:

Loss Time From Work: Start Date:_____Ending Date :_____

Lost Salary/Wages/Opportunity:_____

_____

_____

Loss of Enjoyment from Hobbies:_____

Loss of Intimacy:_____

Enjoyment of Family:_____

Other Suffering:_____

SECTION 4: REMEDIES

WHAT WOULD YOU LIKE TO ACHIEVE:

_____

_____

ANY SETTLEMENT OFFER(S) MADE:

_____

REMARKS:

_____

_____

_____

_____

_____

INTERNAL/OFFICE USE:

_____

_____

_____