

# Personal Injury Questions

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ M F Date of injury: \_\_\_\_\_

Patient complaints:

Hearing Loss:      None   R   L   Both      When did it start?

Tinnitus (ringing in the ears): None   R   L   Both      When did it start?

- How often
- Describe

What happened?: