Confidential Medical Negligence Questionnaire
INSTRUCTIONS

Please answer the following questions as fully and accurately as possible. A full and complete disclosure is critical. The following information will be needed in order to properly advise you and handle your case. Please print and fill out every applicable question. If a question is not applicable, please write N/A in the space. Do not leave blanks. This information will help us help you. This information will be kept confidential.

If you need more space, please attach another sheet and clearly indicate which question you are answering. If you are not certain about an answer, leave the space blank. If any question is not applicable, write “N/A” in the blank. You may wish to make a copy to retain for your own records.

You need to keep attorney advised as to your current address and phone number(s).

Any of the information provided to us by you in this questionnaire will be held in the strictest confidence by the Noland Law Firm, LLC.
MEDICAL NEGLIGENCE QUESTIONNAIRE

DATE: __________________________

BACKGROUND:

FULL NAME: _________________________________________________________________
ADDRESS: ________________________ CITY_______________ STATE: _____ ZIP_______
PHONE: (H) _____________________ (W) __________________ OTHER ________________
CELL: ___________________________ EMAIL:__________________________________
SSN: ____________________________ DOB: __________________________________
EDUCATION: _________________________________________________________________
MARITAL STATUS: (M) (S) (D) ________________________________________________
PRIOR MARRIAGES, IF SO LIST: ______________________________________________

SPOUSE’S BACKGROUND:

FULL NAME: _________________________________________________________________
ADDRESS: ________________________ CITY_______________ STATE: _____ ZIP_______
PHONE: (H) _____________________ (W) __________________ OTHER ________________
CELL: ___________________________ EMAIL:__________________________________
SSN: ____________________________ DOB: __________________________________
EDUCATION: _________________________________________________________________

PERSON WHO WILL ALWAYS KNOW YOUR WHEREABOUTS:

NAME: __________________________________ RELATIONSHIP: ____________________
ADDRESS: ________________________ CITY_______________ STATE: _____ ZIP_______
PHONE: (H) _____________________ (W) __________________ OTHER ________________

WHO REFERRED YOU TO OUR OFFICE? __________________________________________

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CHILDREN:
PLEASE FURNISH FULL NAME, ADDRESS, BIRTH DATE AND AGE OF ALL CHILDREN:

FULL NAME:___________________________________________________________
PRESENT ADDRESS:_____________________________________________________
DATE OF BIRTH:________________________________________________________
AGE:___________________________________________________________________

FULL NAME:___________________________________________________________
PRESENT ADDRESS:_____________________________________________________
DATE OF BIRTH:________________________________________________________
AGE:___________________________________________________________________

FULL NAME:___________________________________________________________
PRESENT ADDRESS:_____________________________________________________
DATE OF BIRTH:________________________________________________________
AGE:___________________________________________________________________

EMPLOYMENT INFORMATION:

EMPLOYER: __________________________________________________________________
ADDRESS: ____________________________ CITY ___________ STATE _____ ZIP _______
TELEPHONE:__________ DATE OF HIRE: ________ LENGTH EMPLOYED:____________
JOB DUTIES:________________________________________________________________
RATE OF PAY: (SALARY) ___________________ (HRLY RATE)______________________
(HRS PER DAY) ___________________ (DAYS PER WEEK) ___________________
(OVERTIME RATE) ___________________ (OVERTIME HOURS) ___________________
(FRINGE BENEFITS) _______________________________________________________
(PART TIME) _____________________________________________________________

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LOST WAGES:
LOST TIME FROM WORK, RATE OF PAY AND, ESTIMATED LOST WAGES AND EXPLAIN HOW YOU HAVE CALCULATED THE SAME:

______________________________________________________________________________

LOSS OF BUSINESS PROFITS OR LOSS OF INCOME FROM OTHER SOURCES:

______________________________________________________________________________

ARE YOU OR HAVE YOU RECEIVED DISABILITY BENEFITS AS A RESULT OF THIS ILLNESS OR INJURY? IF YES, PLEASE DESCRIBE:

______________________________________________________________________________

HEALTH INSURANCE INFORMATION:
THE NAME OF YOUR PRIMARY/PRIVATE HEALTH INSURANCE CARRIER AND THE GROUP OR POLICY NUMBER OF SAME.

______________________________________________________________________________

OTHER ASSISTANCE:
ARE YOU A MEDICAID RECIPIENT? IF YES, PLEASE PROVIDE YOUR MEDICAID NUMBER.

______________________________________________________________________________

ARE YOU A MEDICARE RECIPIENT? IF YES, PLEASE PROVIDE YOUR MEDICARE NUMBER.

______________________________________________________________________________

DO YOU RECEIVE SOCIAL SECURITY BENEFITS? IF SO, PLEASE STATE MONTHLY AMOUNT

______________________________________________________________________________

WERE MEDICARE OR MEDICAID BENEFITS PAID IN ASSOCIATION WITH THE BELOW LISTED MEDICAL TREATMENT? YES _____ NO _______
INFORMATION REGARDING INCIDENT:
IDENTIFY ALL HEALTH CARE PROVIDERS YOU BELIEVE CAUSED YOUR INJURY.
______________________________________________________________________________
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THE CONDITION FOR WHICH YOU WERE BEING TREATED: ______________________
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DESCRIBE IN DETAIL HOW AND WHY YOU BELIEVE THE INCIDENT OCCURRED.
INCLUDE IN YOUR RESPONSE THE SOURCE OF THIS INFORMATION OR BELIEF.
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LIST THE NAME AND ADDRESS OF ALL HEALTH CARE PROVIDERS (DOCTORS, NURSES, HOSPITALS, TECHNICIANS, OR OTHER HOSPITAL OR MEDICAL PERSONNEL) WHO WERE INVOLVED IN THE INCIDENT. _________________________
____________________________________________________________________________
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WERE YOU REFERRED TO THESE HEALTH CARE PROVIDERS BY ANYONE?
YES _________ NO _________
IF SO, BY WHOM? ____________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

LIST THE NAME AND ADDRESS OF ALL DOCTORS, NURSES, TECHNICIANS, OR OTHER MEDICAL OR HOSPITAL PERSONNEL WHO EXAMINED YOU, INTERVIEWED YOU, OR CAME INTO CONTACT WITH YOU BEFORE THE INCIDENT. ____________
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DID YOU HAVE ANY PREVIOUS CONTACT WITH ANY OF THE SAME DOCTORS, NURSES, TECHNICIANS, MEDICAL OR HOSPITAL PERSONNEL BEFORE THE DAY THE INCIDENT OCCURRED? YES _________ NO _________
IF SO, GIVE DETAILS __________________________________________________________
______________________________________________________________________________
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WERE YOU ASKED TO SIGN ANY WAIVER FORMS, IMPLIED CONSENT FORMS, OR OTHER DOCUMENTS BEFORE OR AFTER THE INCIDENT?
YES _________ NO _________
IF SO, DID YOU SIGN? YES _________ NO _________
DO YOU HAVE A COPY OF THE DOCUMENT? YES _________ NO _________

WERE ANY OF THE PERSONS INVOLVED YOUR REGULAR TREATING PHYSICIAN?
YES _________ NO _________
IF SO, GIVE HIS/HER NAME AND ADDRESS. ______________________________________
______________________________________________________________________________
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LIST THE NAME AND ADDRESS OF ALL DOCTORS, NURSES, TECHNICIANS, MEDICAL OR OTHER HOSPITAL PERSONNEL WHO CAME IN CONTACT WITH YOU OR TREATED YOU AFTER THE INCIDENT. ______________________________________
______________________________________________________________________________
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DID YOU GIVE A HISTORY TO ANYONE?  
YES __________   NO __________  
IF SO, TO WHOM? ____________________________________________________________  
______________________________________________________________________________  

IF YOU YOURSELF DID NOT GIVE A HISTORY, DID ANYONE GIVE A HISTORY ON YOUR BEHALF?  YES __________   NO __________  
IF SO, WHO GAVE THE HISTORY? ______________________________________________  
______________________________________________________________________________  
TO WHOM? __________________________________________________________________  
______________________________________________________________________________  

HAVE YOU RECEIVED ANY DOCUMENTS FROM THE HEALTH CARE PROVIDERS, THEIR INSURANCE CARRIERS, OR THEIR ADJUSTERS CONCERNING THE INCIDENT?  YES __________   NO __________  
IF SO, DO YOU HAVE COPIES?  YES __________   NO __________
DID YOU GIVE ANY STATEMENTS TO ANYONE CONCERNING THE INCIDENT?  
YES __________  NO __________
IF SO, TO WHOM DID YOU GIVE THE STATEMENT, WHERE AND WHEN DID YOU GIVE THE STATEMENT AND DO YOU HAVE A COPY? ____________________________
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LIST THE NAMES AND ADDRESSES OF ALL WITNESSES TO THE INCIDENT. INCLUDE ANY PERSONS WHO ACCOMPANIED YOU TO THE HOSPITAL OR DOCTOR’S OFFICE. _______________________________________________________
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HAVE YOU SPOKEN TO ANY OF THE DEFENDANTS, THEIR AGENTS, OR TO ANY OTHER PERSON ABOUT THE INCIDENT?  YES __________  NO __________
IF SO, GIVE DETAILS. __________________________________________________________________________
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WERE ANY PHOTOGRAPHS, PICTURES OR FILMS TAKEN OF YOU AFTER THE INCIDENT? YES _________ NO _________

IF SO, WHO TOOK THEM, WHEN, AND WHERE? __________________________________________
________________________________________
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DO YOU HAVE A COPY? YES _________ NO _________

WERE YOU BEING TREATED AT THE TIME OF THE INCIDENT FOR A CONDITION OR INJURY WHICH YOU SUSTAINED IN THE COURSE OF YOUR EMPLOYMENT? YES _________ NO _________

HAS ANY OTHER HEALTH CARE PROVIDER EVER TOLD YOU THAT MALPRACTICE WAS COMMITTED? YES _________ NO _________

IF SO, IDENTIFY THE HEALTH CARE PROVIDER. ________________________________
________________________________________
________________________________________

PROVIDE THE DATE THAT YOU WERE FIRST GIVEN THIS KNOWLEDGE. _________
________________________________________
________________________________________

WHAT DID THE HEALTH CARE PROVIDER TELL YOU? ___________________________
________________________________________
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MEDICAL TREATMENT:
PLEASE LIST BELOW THE MEDICAL CARE PROVIDERS INVOLVED IN THE
ABOVE INCIDENT/OCCURRENCE. ATTACH A SEPARATE SHEET IF
NECESSARY.

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<th>HOSPITALS</th>
<th>TREATMENT</th>
<th>DATES OF SERVICES</th>
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<th>DOCTORS</th>
<th>TREATMENT</th>
<th>DATES OF SERVICES</th>
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<th>PHYSICAL THERAPY</th>
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<th>DATES OF SERVICES</th>
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### PHARMACIES

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<th>PRESCRIPTIONS</th>
<th>DATES OF SERVICES</th>
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### MEDICAL DEVICES

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### PRESENT COMPLAINTS

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### PRIOR ACCIDENT(S) (TO INCLUDE: car accidents, slip and falls, and any other accidents in which you received injuries)

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**PRIOR INJURIES** (TO INCLUDE: All vehicular injuries, falls, military, sport)

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**PRIOR HOSPITALIZATIONS**: (TO INCLUDE: every time you have been hospitalized in the last 20 years)

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**OTHER INFORMATION:**

HAVE YOU EVER BEEN ARRESTED OR CONVICTED OF A CRIMINAL OFFENSE?

FELONY: YES ___ NO ___  MISDEMEANOR: YES ___ NO ___

IF YES, LIST: OFFENSE, DATE & JURISDICTION ______________________________

________________________________________________________

HAVE YOU EVER BEEN A PARTY IN ANY PREVIOUS LAWSUITS OR MADE A CLAIM FOR PERSONAL INJURY? IF SO, PLEASE DESCRIBE IN DETAIL:

________________________________________________________

________________________________________________________

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HAVE YOU KEPT ANY DIARIES OR CALENDARS OF EVENTS ASSOCIATED WITH THIS ILLNESS OR INJURY? IF YES, PLEASE IDENTIFY: ____________________________________________

________________________________________________________

________________________________________________________

HAVE YOU EVER FILED FOR BANKRUPTCY? YES ___ NO ___
IF SO, WHEN?

ARE YOU PLANNING OR CONSIDERING FILING FOR BANKRUPTCY IN THE NEXT 6 MONTHS? YES ___ NO ___

YOU MUST NOTIFY YOUR ATTORNEY IF YOU ARE CONSIDERING OR IF YOU OR YOUR SPOUSE FILE FOR BANKRUPTCY.

ANY OTHER INFORMATION YOU FEEL IMPORTANT AND WOULD LIKE TO PROVIDE:

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

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________________________________________________________

DATE: _____________________ __________________________________________

CLIENT

THIS INFORMATION IS CONFIDENTIAL AND ONLY FOR THE USE OF NOLAND LAW FIRM, LLC.

End of questionnaire

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