EDGE LAW FIRM, P.C.

MEDICAL / PHYSICAL WORKSHEET

Please provide us with the names of each and every physician, dentist, nurse, and/or other medical/health professional whom you have seen in the last 10 years; the names of any hospital or emergency room to which you were admitted or visited; and indicate means of payment for review of medical records; for any brief physical examination scheduled at your request. Thank you for your time and effort in completing this form. It will help us help you.

1. Name: _____ Age: _____
2. Weight: _____
3. Height: _____
4. List ALL medications you take: _____

_____

5. List all medications including over-the-counter drugs taken within 24 hours of your arrest:

_____

_____

6. **EYES/HGN**

Do you wear glasses? ***Yes*** ***No***

Do you wear contact lenses? ***Yes*** ***No***

On the day of your arrest, did you do anything which would cause eye strain? ***Yes*** ***No***

If yes, what? _____

Have you been diagnosed as having Eye Muscle Fatigue? ***Yes*** ***No*** If yes, when? _____

Have you been diagnosed with dry eyes? ***Yes*** ***No*** If yes, when? _____

Have you been diagnosed with conjunctivitis? ***Yes*** ***No*** If yes, when? _____

Have you been diagnosed or treated for Glaucoma? ***Yes*** ***No*** If yes, when? _____

Do you have a "Lazy Eye" or are you "Cross-Eyed"? ***Yes*** ***No***

Are you under the care of an Ophthalmologist? ***Yes*** ***No***

Name of Doctor: _____

Address/Phone of Doctor: _____

Condition: _____

On the day of your arrest had you ingested:

O Caffeine How many cups? _____

O Nicotine How much? _____

O Aspirin How many? _____

O Antihistamines What dosage? _____

O Other? _____

On the day of your arrest, did you have or, had you suffered from: (check all that apply)

O Flu	O Cold	O Arteriosclerosis
O Hypertension	O Hypotension	O Streptococcus Infection
O Measles	O Muscular Dystrophy	O Multiple Sclerosis
O Epilepsy	O Brain Hemorrhage	O Inner Eye Injuries
O Bilateral Amblyopia	O Unusual Sleep Pattern	O Vertigo
O Dyslexia	O Any other diagnosed eye problem: _____	

Doctor's name, address, & phone if different than above:

_____

_____

_____

7. **EARS/HEARING**

Do you wear a hearing aid? ***Yes*** ***No***

Do you have any diagnosed hearing defects? ***Yes*** ***No***

Do you have any diagnosed auditory processing defects? ***Yes*** ***No***

Have you had any inner ear infections? ***Yes*** ***No*** If yes, when? _____

Have you suffered any injury to your ears? ***Yes*** ***No***

If yes, when? _____

What injury? _____

Do you get swimmer's ear? ***Yes*** ***No***

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

8. **BODY TEMPERATURE**

What is your normal body temperature?

On the day of your arrest, was your body temperature higher than normal? ***Yes*** ***No***

If yes, what was it? _____

Within 24 hours of your arrest, did you have a fever? ***Yes*** ***No***

If yes, what was it? _____

If female, did you have your period or, were you pre-menstrual at the time of your arrest?

Yes ***No*** If yes, which one? _____

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

9. **LUNGS & RESPIRATORY SYSTEM**

Do you have Asthma? ***Yes*** ***No***

Do you have COPD (Chronic Pulmonary Obstructive Disease)? ***Yes*** ***No***

Do you smoke? ***Yes*** ***No*** How much per day? _____

Do you have lung cancer? ***Yes*** ***No***

Do you have Lymphoma? ***Yes*** ***No***

Do you have Hodgkin's Disease? ***Yes*** ***No***

Do you have throat cancer? ***Yes*** ***No***

Do you have any other diagnosed ailment of the respiratory system? ***Yes*** ***No***

If yes, what? _____

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

10. **ENDOCRINE SYSTEM**

Are you diabetic? ***Yes*** ***No***

Type I or Type II? _____

Do you take insulin? ***Yes*** ***No*** If yes, dose: A.M. _____ P.M._____

Are you on oral medication? ***Yes*** ***No*** If yes, what? _____

On the day of your arrest were you hypoglycemic or hyperglycemic? ***Yes*** ***No***

If yes, which one? _____ What time? _____

Have you ever had yeast infections? ***Yes*** ***No*** If yes, how often? _____

Were you taking antibiotics on the day of your arrest? ***Yes*** ***No***

If yes, what kind? _____

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

11. **GASTROINTESTINAL SYSTEM**

Gastric Reflux Disease? ***Yes*** ***No***

Esophageal Hernia? ***Yes*** ***No***

Heartburn? ***Yes*** ***No***

Do you use Tagament, Zantac or other anti-heartburn medication? ***Yes*** ***No***

If yes, what do you use? _____

Do you suffer from any urinary tract infections? ***Yes*** ***No***

Do you suffer from bladder infections? ***Yes*** ***No***

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

12. **SKELETAL SYSTEM**

Have you suffered injuries to, or have deformities in your:

Feet? ***Yes*** ***No*** If yes, when and what? _____

Ankles? ***Yes*** ***No*** If yes, when and what? _____

Knees? ***Yes*** ***No*** If yes, when and what? _____

Legs? ***Yes*** ***No*** If yes, when and what? _____

Back? ***Yes*** ***No*** If yes, when and what? _____

Spine? ***Yes*** ***No*** If yes, when and what? _____

Hands/Fingers? ***Yes*** ***No*** If yes, when and what? _____

Neck? ***Yes*** ***No*** If yes, when and what? _____

Do you suffer from arthritis? ***Yes*** ***No*** If yes, where? _____

Are you "Pigeon Toed"? ***Yes*** ***No***

Are you "Bow Legged?" ***Yes*** ***No***

13. **MUSCULAR SYSTEM**

At the time of your arrest, did you have any muscle:

Strains? ***Yes*** ***No*** If yes, where? _____

Sprains? ***Yes*** ***No*** If yes, where? _____

Tears? ***Yes*** ***No*** If yes, where? _____

Atrophy? ***Yes*** ***No*** If yes, where? _____

Cramps? ***Yes*** ***No*** If yes, where? _____

Have you suffered any disease of the muscles? ***Yes*** ***No***

If yes, what? _____

Do you Ataxia? ***Yes*** ***No***

Do you have any condition which you believe affects your balance and coordination? ***Yes*** ***No***

If yes, what is it? _____

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

14. **CIRCULATORY SYSTEM**

Do you have heart disease? ***Yes*** ***No***

Do you have circulatory problems? ***Yes*** ***No*** If so, where? _____

Do you take any blood thinners? ***Yes*** ***No*** If so, what? _____

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

15. **NEUROLOGICAL/PSYCHOLOGICAL/PSYCHIATRIC**

Have you ever suffered a stroke? ***Yes*** ***No*** If yes, when? _____

Do you have any partial paralysis? ***Yes*** ***No*** If yes, where? _____

Have you ever suffered any injury to the brain? ***Yes*** ***No*** If yes, when? _____

Any lasting effects? _____

Have you ever seen a psychologist or psychiatrist? ***Yes*** ***No*** If yes, when? _____

What was the diagnosis? _____

Were you placed on medication? ***Yes*** ***No*** If yes, what? _____

Have you been diagnosed with Attention Deficit Disorder? ***Yes*** ***No*** If yes, when? _____

Do you suffer from headaches? ***Yes*** ***No*** Migraines? ***Yes*** ***No***

If so, how often? _____

Do you suffer from Depression? ***Yes*** ***No***

Do you experience Anxiety Attacks? ***Yes*** ***No***

Do you get nervous easily? ***Yes*** ***No***

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

16. **THE MOUTH**

Do you have periodontal disease? ***Yes*** ***No***

Do you wear a partial plate or dentures? ***Yes*** ***No***

Do you have any extensive Bridge work? ***Yes*** ***No***

Do you have any loose caps or crowns? Yes No

Do you have a tongue stud? ***Yes*** ***No***

Do you have any condition which introduces blood into your mouth? ***Yes*** ***No***

If yes, what? _____ How? _____

Were you taking antihistamines on the date of your arrest? ***Yes*** ***No***

If yes, what kind? _____ How often? _____

Name, Address, Phone Number of doctor if different from above:

_____

_____

_____

17. **GENERAL INFORMATION**

Do you have any condition which would affect your ability to perform field sobriety tests? ***Yes*** ***No*** If yes, what? _____

Do you have any condition which might make you appear to be intoxicated? ***Yes*** ***No***

If yes, what? _____

_____

Were you pepper sprayed or sprayed with mace? ***Yes*** ***No***

18. **ACCIDENT CASES** (to be filled out **only** if you were in an accident)

Did you hit your head? ***Yes*** ***No***

Were you injured in any way? ***Yes*** ***No*** If yes, how? _____

Were you wearing a seat belt? ***Yes*** ***No***

Did you air bag deploy? ***Yes*** ***No***

Were you taken to a hospital? ***Yes*** ***No*** If yes, which one? _____

Location of hospital: _____

Were you put on an IV prior to having your blood withdrawn? ***Yes*** ***No***

Do you remember talking with a police officer? ***Yes*** ***No***

Were you ever unconscious? ***Yes*** ***No*** If yes, when? _____

Were you admitted? ***Yes*** ***No***

Name of attending physician: _____

_____ _____

Date Full Name