MEDICAL UPDATE SHEET

TO: **DATE:_____**
INCIDENT OF:

We are making progress on your case, and in order to keep us up to date, we need information from you regarding your present condition. Please answer the following questions as best you can by placing a **circle** around the "Yes" or "No" **and completing all questions marked by "Yes".**

PLEASE PRINT LEGIBLY AND SUPPLY COMPLETE NAMES AND ADDRESSES OF YOUR TREATERS

1. Are you still seeing a doctor for the injuries that you received in this accident? Yes No

   a) If yes, what is the name and address of the doctor?

   b) For what injuries is the doctor treating you?

   c) Date you last saw the above physicians(s)?

   d) Do you have any future appointments with the above physician(s)? If so, when?

2. Before you saw the above doctor, did you seen any other doctors, or were you a patient in any hospital for injuries received in this accident? Yes No

   a) Please state the names and addresses of each doctor and hospital, and the approximate date of treatment.

   b) Please state the injuries for which you saw the above doctor(s) or hospital(s).

3. Did you lose any time from work because of your injuries? Yes No

   a) If so, have you returned to work yet? Yes No

4. Do you still have pain because of this accident? Yes No

5. Do you have any scars because of this accident? Yes No

   IF SO, PLEASE ATTACH 5 TO 10 CLEAR COLOR PHOTOS DEPICTING THE SCARRING!

6. Where are the scars?_____

7. Because of your injuries did you have anyone help clean your home or take care of you or your children? Yes No

8. Since this accident have you been injured in another accident, or slip and fall, at work or in an automobile? Yes No

9. Please attach copies of all doctor, hospital, car repair or prescription bills and any other bills you have concerning this accident.

EVEN THOUGH YOU MAY HAVE ANSWERED THIS FORM BEFORE, THIS MUST BE COMPLETED AND RETURNED TO THIS OFFICE WITHIN TEN (10) DAYS.