S.O.L. Patient __________

Others _________

(For Office Use Only)

# MEDICAL MALPRACTICE QUESTIONNAIRE

**Today's Date**: ________________________

## A. PATIENT INFORMATION

1. **NAME:** ______________________________________________

2. **SOCIAL SECURITY NO.:** ________________________________

3. **SPOUSE'S NAME:** ______________________________________

   **SPOUSE'S SOCIAL SECURITY NO.:** _______________________

4. **PATIENT ADDRESS:** ____________________________________

   ____________________________________

5. **PHONE:** (H) ____________ (W)_____________ (CELL) ________________

6. **DATE OF BIRTH:** ____________________________

   **Is the patient deceased?** (circle) NO YES

   **If yes, WHEN?** ___________

   **If yes, is there an open estate?** NO YES

7. **AGE:** ____________

8. **PLACE OF EMPLOYMENT:** ________________________________

9. **OCCUPATION:** _________________________________________

10. **CHILDREN (NAMES AND AGES):** __________________________

    ______________________________________________________

    ______________________________________________________

**B. CASE INFORMATION**

11. **WERE YOU REFERRED TO US BY ANOTHER ATTORNEY?** ______________________

**IF YES, ATTORNEY'S NAME AND ADDRESS:** ______________________

______________________

12. **PLEASE TELL US WHAT HAPPENED** ______________________

13. **WHO DO YOU THINK THAT YOU HAVE A MEDICAL MALPRACTICE CASE AGAINST?**

14. **ON WHAT DATE DO YOU BELIEVE THE MALPRACTICE OCCURRED?**

15. **ON WHAT DATE DID YOU DISCOVER THAT THE MALPRACTICE OCCURRED?**

16. **NAME ALL DOCTORS OR HOSPITALS WHO TREATED YOU:**

17. **DID INSURANCE COVER ANY OR ALL OF YOUR MEDICAL EXPENSES?**

18. **WHAT WAS THE TOTAL AMOUNT INSURANCE HAS PAID TO DATE?**

19. **INSURANCE COMPANY AND POLICY NUMBER FOR ALL INSURANCE COMPANIES THAT HAVE PAID FOR MEDICAL EXPENSES RELATED TO THIS INJURY:**

20. **HOW MUCH HAVE YOU PAID OUT OF POCKET FOR YOUR MEDICAL EXPENSES?**

______________________________________________________________________

21. **DID YOU HAVE ANY OTHER MEDICAL PROBLEMS?** ______________________

22. **DOES YOUR FAMILY HISTORY SHOW ANY INHERITED MEDICAL PROBLEMS?**

______________________________________________________________________

23. **IF YES, WHAT?** ____________________________________________________

24. **WHAT EXACTLY ARE YOUR DAMAGES (EXPENSES, INJURIES, ETC.) AS A RESULT OF THE MALPRACTICE?**

    **HOW WILL THEY AFFECT YOU IN THE FUTURE:** ________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

25. **HOW IS YOUR LIFE DIFFERENT NOW?** __________________________________

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______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

26. **IS THERE ANY SCARRING?** ___________________________________________

______________________________________________________________________

______________________________________________________________________

27. **WILL YOU HAVE TO HAVE MORE SURGERY TO CORRECT THE PROBLEM? IF SECOND SURGERY WAS REQUIRED: DID THE SURGERY GO ALL RIGHT?**

______________________________________________

______________________________________________

______________________________________________

28. **DID YOU DISCUSS THIS PROBLEM/MISDIAGNOSIS/MALPRACTICE WITH YOUR PHYSICIAN?** ______________________________________

______________________________________________

______________________________________________

______________________________________________

29. **WERE YOU ON ANY SPECIAL MEDICATION?** ____________________

30. **DID YOU LOSE ANY INCOME AS A RESULT OF THE PROBLEM/ MISDIAGNOSIS/MALPRACTICE?** ____________________________

______________________________________________

______________________________________________

______________________________________________

31. **WILL YOU BE ABLE TO CONTINUE IN THIS FIELD NOW?** ____________

______________________________________________

______________________________________________

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