FLORIDA FAMILY TELEHEALTH **TELE-EMC**

Review of Systems

Medications (name, dose, frequency)?

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: (meds, foods, etc.)? _____

Past medical history: (heart disease, kidney disease, cancer, BP, etc.)?

_____

Prior surgeries and hospitalization (for any complaint)?

_____

INJURY QUESTIONS

Were you the driver or passenger? _____

Were you wearing a seatbelt? ☐ *Yes* ☐ *No*

Where were you in the automobile? _____

Did you hit your head? ☐ *Yes* ☐ *No* Did you lose consciousness? ☐ *Yes* ☐ *No*

Were you at a ☐ *street light*, or ☐ *stop sign*, or ☐ *were you moving* at the time of the collision?

Were you ambulatory at the scene? _____

Did EMS or Fire Rescue respond? ☐ *Yes* ☐ *No*

Were you transported to the hospital? ☐ *Yes* ☐ *No*

Did you receive any other medical treatment immediately following the injury (i.e. hospital, urgent care)? _____

_____

What part of the body is injured?

_____ _____ _____

_____ _____ _____

_____ _____ _____