

**Trauma Questionnaire**

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| # | **HISTORY** | **Response** |
| 1 | When did the trauma occur? |  |
| 2 | How did the trauma occur? |  |
| 3 | Which side did the trauma occur on? | [ ] Right[ ] Left[ ] Both |
| 4 | Briefly describe the type of trauma that occurred, to the best of your knowledge |  |
| # | **TRAUMA QUESTIONS** | **No** | **Yes** |
| 5 | Are you experiencing any tearing? | □ | □ |
| 6 | Are you experiencing any double vision? | □ | □ |
| 7 | Are you experiencing any new flashing lights or floaters? | □ | □ |
| 8 | Are you been prescribed medications for the trauma? | □ | □ Which medications?(please circle if you are still using) |
| 9 | Was a CT/MRI performed? | □ | □ What facility performed this? |
| 10 | Did you receive any surgical intervention for the trauma? | □ | □ What? |
| 11 | Did you lose consciousness as a result of the trauma? | □ | □ |
| 12 | Were you hospitalized for care as a result of the trauma?  | □ | □ |