

Collier Sports Medicine and Orthopaedic Center  
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Naples, FL 34110

Welcome to our Practice Please fill out completely

**MEDICAL HISTORY FORM**

NAME: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_  
DATE: \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

<b>ACCIDENT OR INJURY DETAILS</b>
THIS ACCIDENT/INJURY OCCURRED WHILE: CIRCLE ALL THAT APPLY
LIFTING                      PULLING                      PUSHING                      TWISTING                      FALLING
BENDING                      REACHING                      SQUATTING                      HIT BY OBJECT
Brief Description of Accident/Injury
Where Did Accident/Injury Occur:
Date of Accident/Injury

I have completed this questionnaire and carefully reviewed its contents. I attest to the accuracy and correctness of the information

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date