# Benton County Coroner Field Investigation Information &
## Medical History / Accident(s) / Injury Questionnaire

Coroner CR #: | Coroner:

Name Of Deceased: _____ DOB: _____

Social Security #: _____ DL #: _____

Sex: ☐ Male ☐ Female ☐ Unk Funeral Home Information:

**Person Providing Medical History:**

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____

Contact Numbers: _____

***Medical History***

| | | | | |
|---|---|---|---|---|
| ☐ Yes | ☐ No | Diabetes | Physician: | |
| ☐ Yes | ☐ No | Hypertension / Hypotension | | |
| ☐ Yes | ☐ No | Dementia / Alzheimer's | Diagnosed Date: | |
| ☐ Yes | ☐ No | Pregnant at this time | Date of Last known Pregnancy: | |
| ☐ Yes | ☐ No | COPD / Pneumonia / Respiratory Failure | On Oxygen: ☐ Yes ☐ No | |
| ☐ Yes | ☐ No | Dizziness / Weakness / Vomiting | Date: | |
| ☐ Yes | ☐ No | Cancer | Type: | Dr: |
| ☐ Yes | ☐ No | Complaining of Chest tightness / Chest pain | Date: | |
| ☐ Yes | ☐ No | Heart Attacks / Stints / Bi Pass / ETC. | Approximate Dates: | |
| ☐ Yes | ☐ No | CVA History | Did it Change way of life: ☐ Yes ☐ No | |
| ☐ Yes | ☐ No | Surgery | Date: | Reason: |
| ☐ Yes | ☐ No | CHF | Depression: ☐ Yes ☐ No | |
| ☐ Yes | ☐ No | Kidney Failure / Liver Failure | Dialysis: ☐ Yes ☐ No | |
| ☐ Yes | ☐ No | Allergies (Food, Medications, ETC.) | Explain: | |
| ☐ Yes | ☐ No | Falls or Fell | Required Medical treatment ☐ Yes ☐ No | |
| ☐ Yes | ☐ No | Long Bone Fractures | Date: | Dr: |
| ☐ Yes | ☐ No | MVA's | Date: | Injuries: ☐ Yes ☐ No |
| ☐ Yes | ☐ No | Physical Altercation | Date: | Injuries: ☐ Yes ☐ No |
| ☐ Yes | ☐ No | Previous Suicide Attempts | Date(s): | |
| ☐ Yes | ☐ No | Has deceased ever Overdosed on Rx's or Alcohol | Date(s): | |
| ☐ Yes | ☐ No | Hx of Subdural Hematomas | Date(s): | |
| ☐ Yes | ☐ No | Hepatitis / MRSA / STD's / Auto Immune Deficiency | Date: | |
| ☐ Yes | ☐ No | Use Of Recreational Drugs | Type Used: | |
| ☐ Yes | ☐ No | Abused (s) Rx Medication | Type Abused: | |

Deceased Diagnosed W/ Agent Orange: ☐ Yes ☐ No ☐ Unk When/Where:

Tobacco Use: ☐ Yes ☐ No ☐ Unk Type used: _____ Amount: _____

Alcohol use: ☐ Yes ☐ No ☐ Unk Been Diagnosed with Alcoholism: ☐ Yes ☐ No ☐ Unk

Chemical Exposure / Causing Health Issues: ☐ Yes ☐ No ☐ Unk Date: _____

Date Deceased last seen alive: _____ Time: _____

Deceased Normal Bed time & Location He/She sleeps: _____

Employment Information & Location:

Is Abuse, Neglect, Domestic abuse or Foul Play Suspected: ☐ Yes ☐ No ☐ Unk ☐ Pending Invest.

Autopsy Requested: ☐ Yes ☐ No By Whom: _____

Agency Completing Body submission:

Signature of Person supplying Information: _____

Coroner Signature: _____