

# Patient Health Questionnaire

Date \_\_\_\_\_ Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex: Male or Female

Brief Description of Injury/Complaint/Problem: \_\_\_\_\_

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Circle Area of Problem: Left Right Both Hand(s) Wrist(s) Forearm(s) or Elbow(s)

Are you Left Handed or Right Handed? (circle one)

If this is a work related injury, what was your date of hire? \_\_\_\_\_

Are you in good health? Yes No

Do you have a pacemaker? Yes No

Are you a smoker? Yes No

If yes, how much do you smoke a day? \_\_\_\_\_

Have you ever been seriously ill? Yes No

Have you ever had any reactions to anesthesia? Yes No

Have you ever been hospitalized? Yes No

If yes, what year and for what reason? \_\_\_\_\_

Have you ever had surgery? Yes No

If yes, what year and for what reason? \_\_\_\_\_

If applicable, when was the date of your last menstrual cycle? \_\_\_\_\_

Have you ever had trouble with excessive bleeding or bruising? Yes No

Are you **ALLERGIC** to any medications? (please list)

\_\_\_\_\_

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Please list any medications you are currently taking (prescribed or over the counter)

\_\_\_\_\_

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Please place an "X" next to any illnesses you have or have had in the past:

|                  |  |                           |
|------------------|--|---------------------------|
| ____ Alcoholism  | ____ Epilepsy                          | ____ Mental Illness       |
| ____ Allergies   | ____ Glaucoma                          | ____ Migraine Headaches   |
| ____ Anemia      | ____ Head/Neck Injury                  | ____ Respiratory Problems |
| ____ Asthma      | ____ Heart Trouble/High Blood Pressure | ____ Rheumatic Fever      |
| ____ Cancer      | ____ Hepatitis                         | ____ Stomach Problems     |
| ____ Diabetes    | ____ Kidney/Liver Problems             | ____ Ulcers               |
| ____ Other _____ |  |                           |

Is there any other information we should know about your health? \_\_\_\_\_

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