PATIENT HEALTH SURVEY

Name: _____DOB:_____ Ht._____ Wt._____

Address: _____

Date of injury/onset _____ Affected Extremity: _____LEFT _____ RIGHT

Reason for today's visit _____

How did this happen? _____

Are you right or left handed? _____ Are you working now? Y N Date Last Worked _____

Employer:_____ Address:_____

Next of Kin/Emergency Contact: _____ Relationship: _____ Phone: _____

ALLERGIES: (Please indicate what type of reaction to the right of the medication):

_____ None	_____ Demerol _____	_____ Penicillin _____
_____ Anesthesia _____	_____ Erythromycin _____	_____ Sulfa _____
_____ Aspirin _____	_____ Iodine _____	_____ Latex Products (rubber gloves
_____ Codeine _____	_____ Morphine _____	Balloons) _____
_____ Dyes for tests _____	Other_____	Other _____

CURRENT MEDICATIONS:_____

_____

PHARMACY:_____ **ADDRESS**: _____

FAMILY PHYSICIAN:_____ **REFERRING PHYSICIAN:**_____

Do You Drink Alcohol? Y N How Much per Week? _____

Do you Smoke? Y N How many years? _____ Packs per day _____ Marijuana or illicit drugs Y N

Any metal in your body? Y N Where? _____

Could you be Pregnant? Y N Are you Claustrophobic? Y N

YOUR MEDICAL HISTORY:

___ Aids/HIV	___ Cancer	___ Hepatitis	___ Pacemakers
___ Anemia	___ COPD/SOB	___ High Blood Pressure	___ Psoriasis
___ Arthritis ___ RA	___ Dialysis/Kidney Disease	___ IBS/Crohns	___ Rheumatic Fever
___ Asthma/Chronic Bronchitis	___ Emphysema	___ Infections/MRSA/VRE	___ Thyroid
___ Bleeding Disorder	___ Epilepsy/Seizures	___ Jaundice	___ Tuberculosis
___ Bone Disease	___ Gout	___ Muscle Weakness	___ Ulcers
___ Diabetes	___ Heart Disease	___ Numbness/weakness	
___ Insulin ___ Pills	___ Heart Murmur	___ Osteoporosis	

Other: _____

SURGICAL HISTORY:

Type of Surgery	Date	Type of Anesthesia	Problems with Anesthesia

Has any member of your family had problems with anesthesia? What type of Problems?

_____

Patient or Parent/Guardian's Signature _____ Date _____