

**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 Balloons) _____
_____ Codeine _____	_____ Morphine _____	_____ Other _____
_____ Dyes for tests _____		

**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 \_\_\_\_\_