Washington University in St. Louis Physicians

Division of Plastics & Reconstructive Surgery
Center for Nerve Injury & Paralysis
Campus Box 8238, 660 S. Euclid Avenue
St. Louis, MO 63110

General Health Questionnaire for Patients with Quadriplegia

Please answer all questions on the following pages by placing a check mark in the appropriate YES or NO column. If necessary, write additional information in the Comment section. This questionnaire must accompany the required medical records to our address/fax number listed at the end of this form.

Patient Name:	**Date of birth:**
Address:	**Date of form completion:**
Level of spinal cord injury:	**Date of spinal cord injury:**
Primary Care Physician:	**Referring Physician or Other (please circle which):**
Address:	Address:
Phone:	Phone:
Current Medications (prescribed and over the counter)	**Allergies to Medications**
(ok to attach list)	
	Do you have a LATEX allergy (circle one)? YES NO

DO YOU HAVE A HISTORY OF	YES	NO	DO YOU HAVE A HISTORY OF	YES	NO
Heart or Circulation Diseases			**Urinary/Kidney/ Bladder Diseases**		
Autonomic dysreflexia			Renal failure and/or dialysis		
Heart attack: *(if yes, when- mo/yr)*			Kidney stones		
Irregular heart beat/palpitations			Frequent urinary infections/urosepsis		
High blood pressure/hypertension			Urinary problems		
Low blood pressure			**Head or Neurologic Diseases**		
Stroke history			Seizure or black outs		
Anemia/sickle cell anemia			Frequent headaches		
Bleeding problems			**Endocrine/ Immunologic Diseases**		

DO YOU HAVE A HISTORY OF	YES	NO
Deep venous thrombosis/pulmonary embolism (blood clot in leg/lungs)		
Swollen ankles/legs/poor circulation		
Cardiac Cath, EKG, Stress Test		
Heart murmur / valve disease		
Lung or Breathing Diseases		
Breathing problems		
Shortness of breath: (*if yes circle when at rest or with exertion)*		
Asthma – *(if yes, when was your last attack)*		
Chronic lung disease		
Pneumonia: were you hospitalized/when?		
Sleep apnea: Do you use CPAP?		
Frequent / productive cough		
Bronchitis		
Abnormal chest x-ray		
Infectious Diseases		
Hepatitis B or C		
HIV or AIDS		
TB / positive PPD		
History of MRSA / C. Difficile		
Any other recent infections/cold?		
Mental Health Issues *(circle)*		
Depression / anxiety / panic disorder		
Anorexia / bulimia / eating disorder		
Violent behavior history		
For Women Only		
Any history of reproductive disease		
Could you possibly be pregnant?		
Date of last menstrual period?		
Number of pregnancies / live births:		
Age at menopause:		
Social History: Single_____ Married ___		
Widowed ____ Divorced____		

DO YOU HAVE A HISTORY OF	YES	NO
Diabetes (*circle all that apply*): controlled by diet / insulin /pills		
Low blood sugar/ hypoglycemia		
Thyroid problems		
Autoimmune /collagen vascular disease		
Do you take steroids (prednisone/other)		
Digestive/Stomach/ Liver Diseases		
Hiatal hernia / acid reflux / ulcers (*circle any that apply*)		
Jaundice (yellow skin)		
Diarrhea		
Constipation		
Difficulty swallowing		
Musculoskeletal/Joint/Skin Diseases		
Spasticity		
Joint contractures		
Joint replacement/ Arthritis		
Any pressure sores		
If yes, please circle- buttock/sacrum heel elbow		
Other skin lesions/rashes/ itching?		
Do you have a Baclofen pump?		
Ear/Nose/Throat/Eye Issues		
Difficulty hearing/speaking (*circle*)		
Dentures / bridge / plate (*circle*)		
Chipped or loose teeth (*circle*)		
Glasses/contact lenses (*circle*)		
Cataracts / glaucoma (*circle*)		
MOBILITY / OTHER FUNCTION		
Type of wheelchair used (circle) Manual / Power		
Independent with feeding?		
Independent with bladder function? (suprapubic/self-cath/other?)		
Independent with bowel function?		
Surgery History		
Any problems with anesthesia?		
Blood products or transfusion?		

Occupation:		
Children (ages):		
	YES	**NO**
Tobacco use?		
Packs per day____ for _____ years Date Quit: _____		
Any other tobacco products? (pipe, cigar, chewing tobacco, etc.) (*circle yes or no*)		
Alcohol use?		
Street drug use? *(circle yes or no) (cocaine, PCP, methamphetamines, marijuana, any IV drugs)*		
***Family History* (please indicate relationship and whether alive/deceased), specifically address:**		
Any problems with anesthesia?		
Any : cancer, cardiac disease, diabetes, seizures		
Other:		

If yes, any reaction?
PAST MEDICAL/SURGICAL HISTORY **Please list any surgery to your spine, shoulders, arms, or hands before or after your spinal cord injury:**
List previous any other surgeries, hospitalizations/major illnesses or anything else we may have missed:

COMMENTS:

_____

_____

What is your HEIGHT :_____ WEIGHT :_____

Once this screening form is completed, you will need to fax the form along with the required medical records to (314) 367-0225, ATTN Dr. Fox & Marci Bailey, RN.

If you do not have access to a fax, medical records can be mailed to:

Washington University School of Medicine
Division of Plastics & Reconstructive Surgery
ATTN: Dr. Ida Fox/Marci Bailey, RN
660 S. Euclid Ave, Campus Box 8238
St. Louis, MO 63110

The required medical records include-

- A comprehensive letter of introduction from your primary care or rehabilitation medicine physician detailing the ASIA/ICSHT classification of your spinal cord injury and description of the functional use of both hands. We must know if elbow flexion and wrist extension are intact. The letter will also need to include the condition of your upper extremities with joint stability, range of motion, spasticity, and contracture.
- Progress notes of physical therapy/rehabilitation program.
- Operative notes from previous spinal surgeries and surgeries to the shoulders, arms, and hands.
- Demographics (address, phone number, date of birth) and health insurance information.

Office use only: *Revised 05/09/2012*

MR receipt date: MR review date: Patient notification date: Visit date: