BARNES-JEWISH Hospital
BJC HealthCare

Washington University in St. Louis
Physicians

Patient Health Survey

Date ____/____/____

Patient's Name _____ Date of Birth ____/____/____

Age_____ Gender: ☐ Male ☐ Female Reason for Visit_____

Home Phone _____ Work Phone _____ Cell Phone_____

PRIMARY CARE PHYSICIAN (PCP)

Name _____

Address_____

PCP Phone _____

REFERRING PHYSICIAN

Name _____

Address_____

M.D. Phone _____

I ALLERGIES TO MEDICATIONS

Are you allergic to any medication(s)? ☐ Yes ☐ No If yes, please list:

_____ _____ _____ _____

_____ _____ _____ _____

II MEDICATIONS

Do you take any?	Yes	No	Name of Drug(s)
Blood pressure pills	☐	☐	
Water pills	☐	☐	
Aspirin	☐	☐	
NSAIDS	☐	☐	
Blood thinners (Coumadin, warfarin, Plavix)	☐	☐	
Steroids	☐	☐	
Insulin	☐	☐	
Neuropathic pain medications (Lyrica, gabapentin)	☐	☐	

Do you take any?	Yes	No	Name of Drug(s)
Other pain medications	☐	☐	
Anti-anxiety medications	☐	☐	
Antidepressant medications	☐	☐	
Herbal medications/ vitamins	☐	☐	
Other medications	☐	☐	

III SURGICAL HISTORY

Have you ever had surgery for the **affected arm or leg** you are seeing Dr. Mackinnon as a new patient for? ☐ Yes ☐ No

If yes → Year	Surgeon	Operation

III SURGICAL HISTORY *continued*

Have you ever had any other surgery? ☐ Yes ☐ No

If yes → Year	Surgeon	Operation

Have you ever had a problem with anesthesia? ☐ Yes ☐ No

If yes, describe _____

Have you ever been involved in a major accident? ☐ Yes ☐ No

If yes, what and when _____

Do you wear contact lenses? ☐ Yes ☐ No

Do you wear a hearing aid? ☐ Yes ☐ No

Do you have loose, chipped or capped teeth? ☐ Yes ☐ No

If yes, explain _____

Do you have any bridgework, braces or dentures? ☐ Yes ☐ No

Have you had any cold or flu-like symptoms in the past 3 weeks? ☐ Yes ☐ No

Do you have a heart condition or need to take an antibiotic before surgery? ☐ Yes ☐ No

IV SOCIAL HISTORY

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Significant Partner

Occupation _____

If work-related problem, please describe in detail your responsibilities at work _____

Previous hobbies _____

Current hobbies _____

Ages of Children _____ ☐ None

Have you ever smoked cigarettes/cigars? ☐ Yes, currently ☐ Yes, but quit ☐ No

If yes, how much per day _____ For how many years_____ If quit, what year _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

What alcohol do you prefer? ☐ Beer ☐ Wine ☐ Hard liquor How many drinks do you drink per week? _____

Have you ever taken illicit drugs? ☐ Yes ☐ No If yes, please check the drugs you have taken:

☐ MARIJUANA ☐ HEROIN ☐ COCAINE ☐ METHAMPHETAMINES ☐ OTHER _____

Are you currently using illicit drugs? ☐ Yes ☐ No If yes, please check the drugs you are taking:

☐ MARIJUANA ☐ HEROIN ☐ COCAINE ☐ METHAMPHETAMINES ☐ OTHER _____

Have you ever been treated for illicit drug use? ☐ Yes ☐ No

If yes, please comment _____

Have you ever been treated for alcohol abuse? ☐ Yes ☐ No

If yes, please comment _____

V FAMILY HISTORY

Is there a family history of heart problems? ☐ Yes ☐ No

List problem(s) and relationship _____

_____

Is there a family history of cancer? ☐ Yes ☐ No

List type(s) and relationship _____

_____

Is there a family history of bleeding problems? ☐ Yes ☐ No

List problem(s) and relationship _____

_____

Is there a family history of diabetes? ☐ Yes ☐ No

List problem(s) and relationship _____

_____

Did/do they take insulin? ☐ Yes ☐ No

Has anyone in the family had a problem with anesthesia? ☐ Yes ☐ No

Is there a family history of neurological diseases? ☐ Yes ☐ No

List problem(s) and relationship _____

_____

_____

VI REVIEW OF SYSTEMS

Have you ever had cancer? ☐ Yes ☐ No

If yes: List when and type(s) _____

Did you have radiation? ☐ Yes ☐ No Did you have chemotherapy treatments? ☐ Yes ☐ No

_____

What is your height? _____ What is your current weight? _____

Has it changed more than 10-15 lbs. in the last year? ☐ Yes ☐ No

If yes: Pounds gained_____ Lost_____ Any reason for the weight change? _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

A. HEART PROBLEMS

	Yes	No	Comment
High blood pressure	☐	☐	_____
Low blood pressure	☐	☐	_____
Rheumatic fever	☐	☐	_____
Heart attack	☐	☐	_____
Heart murmur	☐	☐	_____
Chest pains	☐	☐	_____
Irregular heart beats	☐	☐	_____
Heart stents	☐	☐	_____
Heart surgery	☐	☐	_____
High cholesterol	☐	☐	_____
Swelling of legs	☐	☐	_____
Leg cramps with walking	☐	☐	_____
Other	☐	☐	_____

B. HEAD AND NECK PROBLEMS

	Yes	No	Comment
Watery or dry eyes	☐	☐	_____
Dry eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Hoarseness	☐	☐	_____
Nose bleeds	☐	☐	_____
Nasal obstruction/ drainage	☐	☐	_____
Environmental allergies	☐	☐	_____
Other	☐	☐	_____

VI REVIEW OF SYSTEMS *continued*

C. LUNG PROBLEMS

	Yes	No	Comment
Asthma	☐	☐	
Hay fever	☐	☐	
Bronchitis	☐	☐	
Pneumonia	☐	☐	
Shortness of breath	☐	☐	
Coughing	☐	☐	
Other	☐	☐	

D. URINARY PROBLEMS

	Yes	No	Comment
Urinary infections	☐	☐	
Kidney stones	☐	☐	
Problems voiding	☐	☐	
Dialysis	☐	☐	
Other	☐	☐	

E. GENERAL

	Yes	No	Comment
HIV	☐	☐	
AIDS	☐	☐	
Jaundice/Hepatitis A	☐	☐	
Hepatitis B	☐	☐	
Hepatitis C	☐	☐	
Problems healing	☐	☐	
Bad scarring	☐	☐	
Blood transfusions	☐	☐	

F. GI PROBLEMS

	Yes	No	Comment
Ulcer	☐	☐	
Heartburn	☐	☐	
Hiatal hernia	☐	☐	
Colitis	☐	☐	
Irritable bowel syndrome	☐	☐	
Chronic disorders	☐	☐	
Pancreatitis	☐	☐	
Other	☐	☐	

G. MUSCULOSKELETAL PROBLEMS

	Yes	No	Comment
Arthritis	☐	☐	
Broken bones	☐	☐	
Trouble opening mouth	☐	☐	
TMJ	☐	☐	
Limited joint motion	☐	☐	
Muscle weakness	☐	☐	
Back pain	☐	☐	
Neck pain	☐	☐	
Muscle pain	☐	☐	
Shoulder pain	☐	☐	
Blood clots in legs	☐	☐	
Other	☐	☐	

H. NEUROLOGIC PROBLEMS

	Yes	No	Comment
Stroke	☐	☐	
Convulsions/seizures	☐	☐	
Head injury	☐	☐	
Fainting/blackouts	☐	☐	
Headaches	☐	☐	
Dizziness	☐	☐	
Numbness or tingling	☐	☐	
Paralysis	☐	☐	
Coordination problems	☐	☐	
Emotional problems	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Anger	☐	☐	
Other	☐	☐	

I. ENDOCRINE/HEMATOLOGIC PROBLEMS

	Yes	No	Comment
Thyroid	☐	☐	
Weight change	☐	☐	
Anemia	☐	☐	
Sickle cell disease or trait	☐	☐	
Bruises easily	☐	☐	
Lymph node enlargement	☐	☐	
Frequent infections	☐	☐	
Diabetes	☐	☐	

J. Other Medical Problems not Mentioned Above