

Patient Health Survey

Patient's Name _____ Date _____ / _____ / _____
 Age _____ Gender: Male Female Reason for Visit _____
 Date of Birth _____ / _____ / _____
 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)	Do you take any?	Yes	No	Name of Drug(s)
Blood pressure pills	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other pain medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Water pills	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			_____
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anti-anxiety medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
NSAIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			_____
Blood thinners (Coumadin, warfarin, Plavix)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Antidepressant medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			_____
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	_____	Herbal medications/ vitamins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuropathic pain medications (Lyrica, gabapentin)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____			_____
				Other medications	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____

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

If yes, explain _____

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

If yes, what and when _____

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 wear contact lenses? Yes No

Do you wear a hearing aid? 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 diabetes? Yes No
List problem(s) and relationship _____

Is there a family history of cancer? Yes No
List type(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 bleeding problems? Yes No
List problem(s) and relationship _____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular heart beats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart stents	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leg cramps with walking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

B. HEAD AND NECK PROBLEMS

	Yes	No	Comment
Watery or dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nasal obstruction/ drainage	<input type="checkbox"/>	<input type="checkbox"/>	_____
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

VI REVIEW OF SYSTEMS *continued*

C. LUNG PROBLEMS

	Yes	No	Comment
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

D. URINARY PROBLEMS

	Yes	No	Comment
Urinary infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems voiding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

E. GENERAL

	Yes	No	Comment
HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaundice/Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	_____
Problems healing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bad scarring	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	_____

F. GI PROBLEMS

	Yes	No	Comment
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

G. MUSCULOSKELETAL PROBLEMS

	Yes	No	Comment
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trouble opening mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
TMJ	<input type="checkbox"/>	<input type="checkbox"/>	_____
Limited joint motion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood clots in legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

H. NEUROLOGIC PROBLEMS

	Yes	No	Comment
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting/blackouts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coordination problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anger	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

I. ENDOCRINE/HEMATOLOGIC PROBLEMS

	Yes	No	Comment
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight change	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle cell disease or trait	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruises easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph node enlargement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____

J. Other Medical Problems not Mentioned Above
