Patient Health Questionnaire

Date:_____ Name:_____ Date of Birth:_____

Age: _____ Height:_____ Weight:_____ Gender: Male or Female

Brief Description of Injury/Complaint/Problem: _____

_____

Circle Area of Problem: Left Hand Right Hand Both Hand(s) Wrist(s) Forearm(s) Elbow(s)

Are You Left-handed or Right-handed? (circle one)

If this is a work related injury, what was your date of hire? _____

Are you in good health? Yes No
Do you have a pacemaker? Yes No
Are you a smoker? Yes No
If yes, how much do you smoke a day? _____
Have you ever been seriously ill? Yes No
Have you ever had any reactions to anesthesia? Yes No
Have you ever been hospitalized? Yes No
If yes, what year and for what reason? _____
Have you ever had surgery? Yes No
If yes, what year and for what reason? _____
If applicable, when was the date of your last menstrual cycle? _____
Have you ever had trouble with excessive bleeding or bruising? Yes No

Are your **ALLERGIC** to any medications? (Please list)

_____

Please list any medications you are currently taking (prescribed or over the counter):

_____

Please place an "**X**" next to any illnesses you have or have had in the past:

____Alcoholism	____Epilepsy	____Mental Illness
____Allergies	____Glaucoma	____Migraine Headaches
____Anemia	____Head/Neck Injury	____Respiratory Problems
____Asthma	____Heart Trouble/High Blood Pressure	____Rheumatic Fever
____Cancer	____Hepatitis	____Stomach Problems
____Diabetes	____Kidney/Liver Problems	____Ulcers

____Other _____

Is there any other information we should know about your health? _____

_____