Patient Health Questionnaire

ROOM: 1 2 3

Patient Name ________________________________ **Date of Birth:** ____________________ **Today's Date:**______________________

Age: ________ **Gender:** M F **Occupation:** ___________________________ **Is this a work-related injury?** Y N

Injured Joint: _____________ Right Left **Date of Injury:** _______________________ **Height:** ________ **Weight:** ________ lbs.

Dominant Hand: Right Left **Circumstances of Onset:** Gradual Sudden

How did your injury occur? No specific injury Contact Injury Noncontact injury Pivot Injury (Circle one: Felt a pop / Did not feel a pop)

Other:____

____

What are your major symptoms? Pain Swelling Stiffness Weakness Instability Locking Popping Numbness Grinding Catching
Difficulty ascending stairs Difficulty descending stairs Pain that wakes you at night

Is your injury preventing you from performing activities of daily life? Yes No

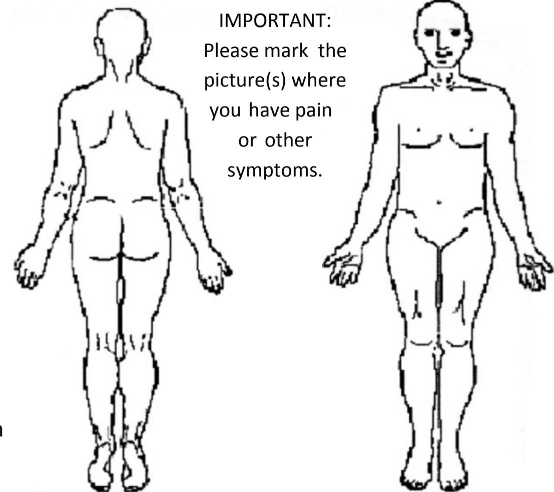
Have you had surgery on the area being evaluated? Yes No

Procedure: ____ Date: _____ / _____ / __________

Procedure: ____ Date: _____ / _____ / __________

Procedure: ____ Date: _____ / _____ / __________

Procedure: ____ Date: _____ / _____ / __________



Location of discomfort: In the front In the back On the inside On the outside All around

Indicate your current level of pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate your level of pain at best: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate your level of pain when it is worst: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

The discomfort is: Improving Worsening Unchanged

The nature of the discomfort is: Sharp pain Dull pain Throbbing Numbness
Shooting Tingling Burning
Constant (76 – 100%) Frequent (51 – 75%)
Occasional (26 – 50%) Intermittent (0 – 25%)

When are your symptoms worse? Morning Afternoon Evening Night As the day goes on
Same all day Other: ______________________

Have you seen anyone for this condition? No Yes – **If yes, who?** ____

ER Visit: **Where?** ____ **Date:** _____ / _____ / __________

Treatments tried for this injury: None Lubrication Injection (Supartz/Synvisc/Orthovisc/Hyalgan) Rest Ice Compression Elevation
Physical Therapy – **How long?** _____________________________ Steroid Injection – **How many?** _______________
Home exercise/stretching Bracing Activity Modification Crutches/cane
Over-the-counter meds – **Which ones?** ____
Prescription meds – **Which ones?** ____

Were any of the above treatments helpful? No Yes – **Which ones?** ____

Has post-injury imaging been performed within the past year? None X-rays MRI CT Scan Other: ____________________________

Which sports or activities do you enjoy? ____

What activities are you unable to participate in? ____

What are your goals? ____

Patient Signature: ____

Patient Health Questionnaire

Patient Name ___________________________________ **Today's Date:** ______________________

Social History

Marital Status: Single Married Domestic Partnership Separated Divorced Widowed Other: _________________________________

Do you have any children? No Yes – How many? ______________

Do you use tobacco? Never No, I quit on (Date) _____ / _____ / _________ Yes – How much? _________________ How long? _____________

Do you use alcohol? No Yes – How much? _________________ How often? _____________

Do you use recreational drugs? No Yes – What type? ______________________ How much? _________________ How long? _____________

Review of Systems – Please indicate if you are *currently* experiencing any of the following:

Yes	No	Constitutional	Yes	No	Integumentary	Yes	No	Neurological
		Recent weight gain or loss			Rash			Headaches
		Amount: + / - ________			Itching			Dizziness
		Fever			Hair loss			Seizures
		Fatigue			**Respiratory**			Numbness/Tingling
		Chills			Cough			**Musculoskeletal**
		Weakness			Wheezing			Joint pain
		HEENT			Shortness of breath			Arthritis
		Blurred vision			**Gastrointestinal**			**Hematologic**
		Double vision			Nausea			Anemia
		Corrected vision			Vomiting			Bruising
		Hearing loss			Diarrhea			Abnormal bleeding
		Sneezing			Heartburn			**Lymphatic**
		Congestion			Abdominal pain			Enlarged glands
		Runny nose			Constipation			**Psychiatric**
		Sore throat			Blood in stool			Anxiety
		Difficulty swallowing			**Genitourinary**			Depression
		Cardiovascular			Painful urination			PTSD
		Chest pain			Frequent urination			**Endocrinologic**
		Palpitations			Dialysis			Sweating
		Abnormal heart rhythm			Kidney failure			Cold/heat intolerance
		Edema			Menopause			Increased thirst
		Syncope			Pregnancy			

Date of last menstrual period: ___/___/_____

Please list any allergies you have and the reaction: ____

____

Personal and Family Medical History – Please indicate if you *currently* or *have previously* experienced any of the following:

Yes	No	Family	Condition
			Anxiety
			Asthma
			Ataxia
			Bleeding/Clotting Disorder
			Blood Clots
			Blood Transfusion
			Cancer – What type? ___________
			Congestive Heart Failure (CHF)
			Coronary Artery Disease (CAD)
			Depression
			Diabetes – Type: ________
			Emphysema or COPD
			Gall Stones
			GERD/Acid Reflux
			Head Injury
			Heart Arrhythmia (A. Fib/SVT/A. Flutter)
			Heart Attack
			Hepatitis – Type: __________
			High Blood Pressure

Yes	No	Family	Condition
			High Cholesterol
			HIV/AIDS
			Kidney Failure
			Kidney Stones
			Liver Disease
			Lyme Disease
			Migraines/Chronic Headaches
			Pancreatitis
			Paralysis
			Peripheral Vascular Disease
			Psoriasis
			Rheumatic Fever
			Seizures/Epilepsy
			Sleep Apnea
			Stomach Ulcer
			Stroke/TIA
			Thyroid Disease
			Tuberculosis
			Other: __________________________________

Current Medications (include dosage, frequency, & reason for taking)**:** ____
____

Previous hospitalizations/surgical procedures and the date(s) they occurred (not including the reason for today's visit)**:** ____
____

Primary Care Physician: Name: ____ Phone: ____

Address: ____

Would you like for us to send a copy of your exam note? Yes No

Patient Signature: ____