600116

HILLCREST HOSPITAL SOUTH
TULSA, OK 74133

HEALTH QUESTIONNAIRE

600116 (02/13)

Name:		Date:
Referring Doctor:	Gender: M F	Age:
Sports Hobbies:		Weight:
Occupation:		

INFORMATION IN REGARDS TO YOUR INJURY

Date of Injury/Onset	Date of Surgery
Body Part to be Treated	
Is this the first injury you have had to this area? Yes No	
Past Treatment(If indicated)	

MEDICAL HISTORY

Do you have any of the following?		
1. Diabetes?	Yes	No
2. Cardiac Pacemaker?	Yes	No
3. Any total Joint Replacement? Where?	Yes	No
4. Arthritis? Where?	Yes	No
5. Unexpected weight loss?	Yes	No
6. Headaches/Migraines?	Yes	No
7. Do you smoke?	Yes	No
8. History of Cancer? Where?	Yes	No
9. History of Cancer in the family?	Yes	No
10. Had previous surgery?	Yes	No
11. Depression due to illness?	Yes	No
12. Psychiatric illness?	Yes	No
13. Currently Pregnant?	Yes	No
14. Heart disease?	Yes	No
15. High/Low blood pressure?	Yes	No
16. Lung disease?	Yes	No
17. Decreased circulation (hands, forearm, feet/legs)?	Yes	No
18. Neck or back pain?	Yes	No
19. Arteriosclerosis?	Yes	No
20. Other illnesses?	Yes	No

Patient Label

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Name: Date:

MEDICATION

Please list your medications, dosage and reasons for taking them: (cont on back of paper if needed)

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____

ALLERGIES: __________________________________

HOW DOES THE PAIN AFFECT YOU?

0=pain free, 2=discomfort, 5=moderate, 8=severe, 10=excruciating

Circle the score that best reflects your status

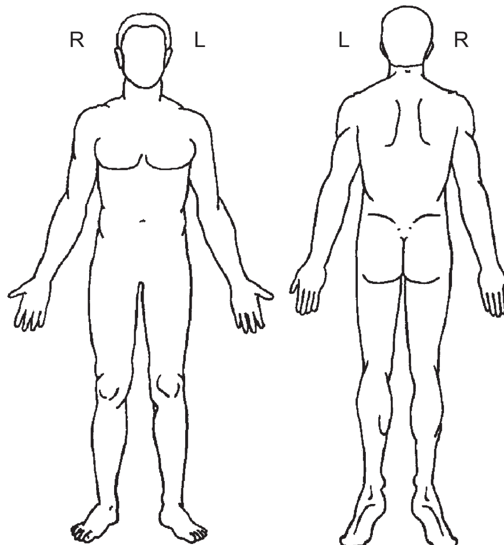
Your CURRENT pain:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
The WORST pain you have had in the last week:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
The LEAST pain you have had in the last week:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Circle the DURATION of your pain:	Brief	Intermittent	Constant
Circle your MEDICATION use:	None	As Needed	Constant

MARK YOUR SYMPTOMS ON THE DIAGRAM BELOW USING THE SUGGESTED SYMBOLS:

Sharp!!! Dull Ache### Numbness/// Tingling+++

Rate your pain areas in order of severity of symptoms using 1, 2, 3, etc.



Patient Label