PATIENT HEALTH SURVEY

NAME ______________________ DATE ____________ MSG DDG

What type of regular exercise do you perform? O **None** O **Light** O **Moderate** O **Strenuous**

Place a check in the appropriate column if you have had or currently have any of the conditions listed below.

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
O	O	**Headaches**	O	O	**High Blood Pressure**	O	O	**Diabetes**
O	O	**Neck Pain**	O	O	**Heart Attack**	O	O	**Excessive Thirst**
O	O	**Upper Back Pain**	O	O	**Chest Pains**	O	O	**Frequent Urination**
O	O	**Mid Back Pain**	O	O	**Stroke**			
O	O	**Low Back Pain**	O	O	**Angina**	O	O	**Smoking/Use Tobacco Products**
O	O	**Shoulder Pain**	O	O	**Kidney Stones**	O	O	**Drug/Alcohol Dependence**
O	O	**Elbow/Upper Arm Pain**	O	O	**Kidney Disorders**	O	O	**Allergies:** ***List***
O	O	**Wrist Pain**	O	O	**Bladder Infection**			________
O	O	**Hand Pain**	O	O	**Painful Urination**			________
			O	O	**Loss of Bladder Control**			________
O	O	**Hip/Upper Leg Pain**						
O	O	**Knee/Lower Leg Pain**	O	O	**Abnormal Weight Gain or Loss**	O	O	**Depression**
O	O	**Ankle/Foot Pain**				O	O	**Systemic Lupus**
O	O	**Restless Leg Syndrome**	O	O	**Loss of Appetite**	O	O	**Epilepsy**
O	O	**Jaw Pain**	O	O	**Abdominal Pain**	O	O	**Dermatitis/Eczema/Rash**
			O	O	**Ulcer**	O	O	**HIV/AIDS**
O	O	**Joint Swelling/Stiffness**	O	O	**Hepatitis**			
O	O	**Arthritis**	O	O	**Liver/Gall Bladder Disorder**			***Females Only***
O	O	**Rheumatoid Arthritis**				O	O	**Birth Control Pills**
O	O	**Fibromyalgia**	O	O	**Cancer**	O	O	**Hormonal Replacement**
O	O	**General Fatigue**	O	O	**Tumor**	O	O	**Pregnancy**
O	O	**Muscular Incoordination**	O	O	**Sleep Apnea**			
O	O	**Visual Disturbances**	O	O	**Asthma**			***Males Only***
O	O	**Dizziness**	O	O	**Chronic Sinusitis**	O	O	**Prostate Problems**
		Other Health Problems / Issues	O	O	________	O	O	________

Indicate if an immediate family member has had any of the following:

O **Rheumatoid Arthritis** O **Heart Problems** O **Diabetes** O **Cancer** O **Lupus** O ________

List all over-the-counter medications and nutritional/herbal supplements you are taking:

________ ________ ________

________ ________ ________

List all the surgical procedures you have had and times you have been hospitalized:

________ ________ ________

________ ________ ________

I understand the above information was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information provided on this form or any changes in my medical status.

Patient's Signature (or guardian**):** ________________ Date: ________

ADVANCED NECK AND BACK CARE CENTER - STEVENS POINT - WI

Revised 5/15

Drs. Initials: ________