Patient Label

UNIVERSITY of CALIFORNIA • IRVINE HEALTHCARE

PATIENT HEALTH SURVEY

NAME _____ AGE _____ M _____ F _____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:
- ☐ Measles ☐ Mumps ☐ Chicken Pox
- ☐ Congenital Abnormalities ☐ Rheumatic fever or heart disease

Adult:
- ☐ Asthma ☐ High Blood Pressure ☐ Cancer (Site _____)
- ☐ Diabetes ☐ Ulcer or Gastritis ☐ Thyroid Problems
- ☐ Tuberculosis ☐ Kidney Problem ☐ Liver Problems
- ☐ Blood Problem ☐ Venereal Disease ☐ Heart Failure
- ☐ Heart Attack ☐ Abnormal Heart Rhythm

Have you had any serious illness?	No	Yes
Have you ever had a transfusion?	No	Yes
Have you ever been hospitalized or been under medical care for very long?	No	Yes

If Yes, for what reason? _____

Most recent immunizations:

Hepatitis B _____ (date) Flu Vaccine _____ (date)

Pneumovax _____ (date) Tetanus _____ (date)

OPERATIONS:

Have you ever had any surgery? No Yes

List: ☐ Appendectomy ☐ Hysterectomy (If so, reason _____)
☐ Ovaries Removed ☐ Joint Replacement
☐ Gallbladder ☐ Bypass (If so, what _____)
☐ Other _____

ALLERGIES: **REACTIONS:**

MEDICATIONS:

INJURIES:

Have you ever been seriously injured in a motor vehicle accident?	No	Yes
Have you had any head concussions or injuries?	No	Yes
Have you ever been knocked unconscious?	No	Yes

SOCIAL HISTORY:

Circle One: Single, Married, Separated, Divorced, Widowed, Significant Other

With whom do you live? _____

Recreational Drug Usage?	No	Yes
Do you have any problems with sexual function?	No	Yes

Foreign travel within last year _____

Coffee _____ Tea _____ Cola's _____ (per day)

Alcoholic Beverages: Never _____ <1 per week _____ 1-5 per week _____ Other _____

Tobacco: ☐ Never Smoked ☐ Quit _____ years ago ☐ Years smoked _____ ☐ Packs per day _____

SOCIAL HISTORY: (continued)

Are you employed? Full Time _____ Part Time _____

What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

How much time have you lost from work because of your health during the past?

Six Months _____ One Year _____ Five Years _____

Education: (Years)

Grade School _____ College _____ Postgraduate _____

Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

FAMILY HISTORY:	Age	Health	If Deceased, Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had?

Stroke	No	Yes	Heart Trouble	No	Yes
Tuberculosis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes			

Has any blood relative ever had?

Cancer	No	Yes	Bleeding Tendency	No	Yes
Type			Gout or other crippling arthritis		
Suicide	No	Yes		No	Yes
Mental Illness	No	Yes	Hereditary Defects	No	Yes

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CIRCLE NO OR YES FOR THOSE THAT APPLY

SYSTEMIC REVIEW: Do you have any of the following?

General Maximum weight _____ Minimum weight _____
Recent weight change? No Yes
Have you been in good general health most of your life? No Yes
Have you recently had?
☐ Weakness ☐ Fever ☐ Chills ☐ Night Sweats
☐ Fainting ☐ Problems Sleeping

Skin:
Skin Disease No Yes
Jaundice No Yes
Hives, eczema or rash No Yes

Head-Eyes-Ears-Nose-Throat (cont'd):
Dry eyes or mouth No Yes
Bleeding Gums - Frequent or Constant No Yes
Blurred Vision No Yes
Date of Last Eye Exam _____
Sneezing or runny nose No Yes
Nosebleeds - Frequent No Yes
Chronic sinus trouble No Yes
Ear disease No Yes
Impaired hearing No Yes
Dizziness or sensation of room spinning No Yes
Frequent or severe headaches No Yes

Respiratory:
Asthma or Wheezing No Yes
Difficulty breathing No Yes
Any trouble with lungs No Yes
Pleurisy or Pneumonia No Yes
Cough up Blood (ever) No Yes

Cardiovascular:
Chest pain, pressure or tightness No Yes
Shortness of breath with walking or lying down No Yes
Difficulty walking two blocks No Yes
Palpitations No Yes
Swelling of hands, feet or ankles No Yes
Awakening in the nights smothering No Yes
Heart murmur No Yes

Gastrointestinal:
Vomiting blood or food No Yes
Gallbladder disease No Yes
Change in appetite No Yes
Hepatitis/Jaundice No Yes
Painful bowel movements No Yes
Bleeding with bowel movements No Yes
Black stools No Yes
Hemorrhoids or piles No Yes
Recent change in bowel habits No Yes
Frequent Diarrhea No Yes
Heartburn or indigestion No Yes
Cramping or pain in the abdomen No Yes
Does food stick in throat No Yes

Endocrine:
Hormone therapy No Yes
Any change in hat or glove size No Yes
Any change in hair growth No Yes
Have you become colder than before - or skin become dryer No Yes

Neck:
Stiffness No Yes
Enlarged glands No Yes

Genitourinary:
Loss of urine No Yes
Blood in urine No Yes
Frequent urination No Yes
Burning or painful No Yes
Night time urinating No Yes
Kidney trouble No Yes
Problem stopping/starting flow of urine No Yes
Testicular mass No Yes
Testicular pain No Yes
Prostate problem No Yes
Sexual Dysfunction No Yes
STD / AIDS Risk No Yes

Gynecological:
First day of last period _____
Age periods started _____
How long do periods last? _____ Days
Frequency of periods every _____ Days
Pain with periods No Yes
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast Lump No Yes
Abnormal Vaginal Discharge No Yes
Breast Discharge No Yes
Pain with Intercourse No Yes
Skin change of Brasst No Yes
Nipple retraction No Yes

Locomotor-Musculoskeletal:
Stiffness or pain in joints (check all that apply)
☐ Finger ☐ Hands ☐ Wrist ☐ Elbows ☐ Shoulders ☐ Neck ☐ Back
☐ Hip ☐ Knee ☐ Toes ☐ Foot ☐ Temporomandibular Joint
Weakness of muscles or joints No Yes
Any difficulty in walking No Yes
Any pain in calves or buttocks on walking relieved by rest No Yes

Neuro-Psychiatric:
☐ Transient blindness ☐ Tremor ☐ Numbness in fingers ☐ Weakness
Have you ever had counselling for your mental health? No Yes
Have you ever been advised to see a psychiatrist? No Yes
Do you ever have, or have had, fainting spells? No Yes
Convulsions No Yes
Paralysis No Yes
Problem with coordination No Yes
Domestic violence No Yes
Depression Symptoms (difficulty sleeping, loss of appetite loss of interest in activities, feelings of hopelessness) No Yes

Hematologic:
Are you slow to heal after cuts? No Yes
Anemia No Yes
Phlebitis or Blood Clots in veins No Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery? No Yes
Have you had abnormal bruising or bleeding? No Yes

Source of information, ifother than patient: _____

Signature of person acquiring this information: _____

Provider _____ Date _____ Signature of Patient _____