PATIENT HEALTH SURVEY

FULL NAME: _____ DOB: _____

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small places	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing but not fainting)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

Do you currently have, or could you be, and Following?

Pregnant	Y	N
Receiving hormone therapy	Y	N
☐ Male ☐ Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants	Y	N
Metal fragments; head/eye/skin	Y	N

In the past 14 days (2weeks), have you Experienced any of the following?

Nausea	Y	N
Vomiting	Y	N
Vertigo	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory issues	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Memory loss	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Head trauma	Y	N
Abnormal period	Y	N