



University of Wisconsin Hospital and Clinics
 600 Highland Avenue • Madison, Wisconsin 53792
PATIENT HEALTH QUESTIONNAIRE

UW Health Sports Medicine Clinic
 Patient Health Questionnaire

Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Referring Physician: _____

What problem can we help you with today? _____

What was the date of injury? or How long have you had this problem? _____

Rate your pain on a scale of 0 to 10 (0 = no pain, 10 = worst pain you ever had).

Today: 0 1 2 3 4 5 6 7 8 9 10
 At its worst: 0 1 2 3 4 5 6 7 8 9 10

Please rate the level to which you feel the following activities are affected by your current problem.
 (0 = no affect, 10 = unable to perform)

Sports: 0 1 2 3 4 5 6 7 8 9 10
 Work: 0 1 2 3 4 5 6 7 8 9 10
 Sleep: 0 1 2 3 4 5 6 7 8 9 10
 Daily Activities: 0 1 2 3 4 5 6 7 8 9 10

Would you describe your pain as: (check all that apply)
 ___ constant ___ on/off ___ sharp ___ dull ___ achy
 ___ burning ___ pressure ___ tingling/electrical

Has any other medical provider seen you for this problem? Yes ___ No ___
 If yes, who? _____

Have you had an x-ray for this problem? Yes ___ No ___
 Have you had an MRI for this problem? Yes ___ No ___
 Have you had an CT for this problem? Yes ___ No ___
 Have you had an EMG for this problem? Yes ___ No ___
 Where were they performed? _____
 Did you bring them with you today? Yes ___ No ___

Were you ever given a diagnosis by another provider for this problem? Yes ___ No ___
 If yes, what was the diagnosis? _____

Have you used any of these techniques for treatment and/or pain control? (check all that apply)
 ___ Rest ___ Ice ___ Ibuprofen (Advil, Motrin) ___ Physical Therapy (Duration) _____
 ___ Aspirin ___ Tylenol ___ Naproxen (Aleve) ___ Splint/brace
 Other (please list) _____

Do you currently have any fevers, chills, or redness associated with your pain? Yes ___ No ___

Do you currently have generalized achiness or pain/achiness in other joints? Yes ___ No ___

Do you have any of the following symptoms?

- muscle weakness loss of range of motion locking/catching
- feeling of giving way/dislocation tenderness to touch limp
- numbness or tingling loss of sensation swelling
- unexplained weight loss

Do you take any medications? Yes ___ No ___

Please list:

Name of Medication	Condition Treated	Name of Medication	Condition Treated

Do you have any medication allergies? No ___ Yes ___ To what? _____
If yes, what kind of reaction do you have? _____

Do you have an allergy to latex? No ___ Yes ___
If yes, what kind of reaction do you have? _____

Have you had previous surgery? If yes, what?
side

- 1. R L Body Part : _____ Surgeon: _____ Year: _____
- 2. R L Body Part : _____ Surgeon: _____ Year: _____
- 3. R L Body Part : _____ Surgeon: _____ Year: _____
- 4. R L Body Part : _____ Surgeon: _____ Year: _____
- 5. R L Body Part : _____ Surgeon: _____ Year: _____

Do any of your close relatives have any bone or joint problems? Yes ___ No ___
If yes, what problems do they have? _____

Do you have or have you ever had any of the following?

- High blood pressure Asthma Arthritis
- Heart disease/Heart attack COPD/Emphysema Cancer
- Heart/Bypass surgery Tuberculosis Hepatitis
- Angioplasty Seasonal allergies Migraine headaches
- Blood clots Stomach ulcers Stroke
- Diabetes Acid reflux/ heart burn
- Kidney disease Rheumatoid arthritis/Lupus/Autoimmune disease(circle)

Do you have any other medical problems that you think we should know about? Please list:

Do you smoke? Yes ___ No ___ How many packs/day? _____ How long? _____

Do you drink alcohol? If yes, how many drinks per week? _____

Is this a Workers Compensation injury? Yes ___ No ___

Are you currently working? Yes ___ No ___
If yes, are you on light duty? Yes ___ No ___

What is your occupation? _____

Thank you for taking the time to provide this information to us. It is very helpful as we work to provide you the best, most efficient and most effective care possible.

The UW Health Sports Medicine Staff

Completed by _____	Date _____	If not patient, relationship to patient _____
Reviewed by _____	Date _____	Time _____