Dear Patient:
We welcome the opportunity to participate in your medical care. To ensure maximum safety and efficiency, we ask that you provide accurate answers to the questions asked relating to your general state of health. Thank you for your help and we look forward to caring for you.

AGE	SEX ☐ MALE ☐ FEMALE	HEIGHT	WEIGHT

LIST ALL OPERATIONS YOU HAVE HAD	DATE

		NO	YES	COMMENTS
ANESTHESIA	1. Have you ever had an anesthetic?			
	2. Have you ever had a problem with anesthesia?			
	3. Has any one related to you ever had a problem with anesthesia?			
RESPIRATORY	4. Do you smoke? If yes, how many packs per day and for how many years?			
	5. Do you have a cough?			
	6. Do you bring anything up when you cough?			
	7. Have you had asthma?			
	8. Do you have a cold?			
	9. Have you ever had an abnormal chest x-ray?			
	10. Have you ever had any difficulties breathing?			
	11. Can you walk up two flights of stairs without getting short of breath?			
	12. Are you ever short of breath at night?			
CARDIOVASCULAR	13. Do you have a heart murmur?			
	14. Have you ever had a heart attack?			
	15. Have you ever had angina or pain in the chest related to your heart?			
	16. Have you ever had an abnormal EKG?			
	17. Have you ever had high blood pressure?			

Questionnaire continues on reverse side

PT NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

PATIENT HEALTH ASSESSMENT (PKT)

U1068

UHN1068 REV FEB 07

PROGRESS – BLUE

		NO	YES	COMMENTS
RENAL	18. Have you ever had Kidney disease?			
	19. Have you ever been jaundiced?			
GI	20. Have you ever had hepatitis?			
	21. Do you have a hiatus hernia or get heartburn?			
	22. Do you use alcohol? If so, how much and how often?			
NEUROLOGICAL	23. Have you ever had a stroke?			
	24. Do you have an arm or leg that becomes numb or weak?			
	25. Have you ever had seizures, episodes of unconsciousness, or fainting?			
	26. Do you have frequent headaches?			
	27. Have you ever had an eye problem or problems with your vision?			
ENDO CRINE	28. Do you have diabetes?			
	29. Have you ever had thyroid problems?			
MUSCULO SKELETAL	30. Do you have back problems?			
	31. Do you have arthritis?			
	32. Do you have any physical disabilities			
GENERAL	33. Do you have any bleeding tendencies?			
	34. Have you ever been anemic?			
	35. Have you used aspirin in the past two weeks? If so, how much?			
	36. Do you have any chipped or loose teeth? Dentures, caps, bridgework, braces?			
	37. Have you ever been under the care of a psychiatrist?			
	38. Is there anything else you feel you should tell us?			
FEMALES				
	39. Could you be pregnant?			

DATE OF LAST PERIOD?	CYCLE	LENGTH	CONTRACEPTIVE METHOD
NUMBER OF PREVIOUS PREGNANCIES?	LIVE BIRTHS	ABORTIONS	STILL BORNS
ANY OTHER COMMENTS?			

PT.NO

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