Name: _____ Date of Birth: _____

Date of Injury: _____ Cause of Injury: _____

Primary Care Physician: _____ Physician's Phone Number: _____

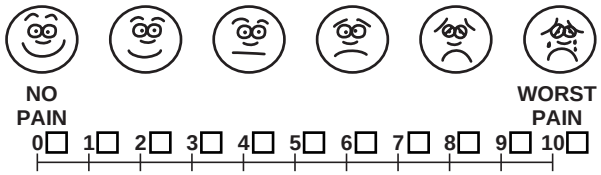
How did you hear about us? _____ Age _____ Height _____ Weight _____

Do you have any medication allergies? ☐ **Yes** ☐ **No**

Allergy:	**Reaction:**

Current Medications (List Name, Dose, & Frequency)

Rate Your Pain (circle):



Pain Location: _____

PAST MEDICAL HISTORY (Please Check All That Apply. Provide Specific Issue & Year of Occurrence)

	Yes	No		Yes	No		Yes	No
Seasonal Allergies			Clotting Issues (Ex. Factor V)			Peripheral Vascular Disease		
Sinus Problems			Pulmonary Embolism (PE)			High Blood Pressure		
Lung Disease (Ex. Asthma)			Deep Vein Thrombosis (DVT)			High Cholesterol		
Use Inhalers			Thyroid Disease			Heart Disease or Heart Attack		
Sleep Apnea/CPAP/BiPAP			Seizure			Mental Health Disorders		
Tuberculosis			Migraines			Depression, Anxiety, Bipolar		
Osteoporosis			Kidney Problems/Dialysis			**Other:**		
Diabetes Mellitus			Liver Disease (Ex. Hepatitis)					
Cancer (Form:_____)			Arthritis (Where:_____)					

PAST SURGICAL HISTORY (Please Check All That Apply. Provide Specific Area & Year it Happened)

	Yes	No		Yes	No		Yes	No
Shoulder Surgery			Gall Bladder Removal			Endarterectomy		
Elbow Surgery			Hysterectomy			Pacemaker or Defibrillator		
Hand/Wrist Surgery			Appendectomy			Coronary Artery Stent(s)		
Hip Surgery			Tonsillectomy			Coronary Artery Bypass Surgery		
Knee Surgery			C-Section (How Many:_____)			(CABG)		
Foot/Ankle Surgery			Mastectomy			Adverse Reaction to Anesthesia		
Spine Surgery			Hernia Repair			**Other:**		
Eye Surgery			Thyroid Surgery					

Are you: ☐ Rt-Handed ☐ Lt-Handed

Any personal or family history of:

☐ Blood Clots ☐ Bleeding Problems ☐ Anesthesia Problems

Flu Vaccine? ☐ Yes ☐ No Date: _____

Pneumonia Vaccine? ☐ Yes ☐ No Date: _____

Tetanus Vaccine? ☐ Yes ☐ No Date: _____

Have you fallen in the past year? ☐ Yes ☐ No

Cultural or Religious Considerations: _____

_____

Do you feel safe in your home? ☐ Yes ☐ No

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Patient Information/Label

Burn Clinic Patient Questionnaire

FAMILY HISTORY (Please Check If Applicable)

	Anesthesia Problems	Bleeding Disorders	Heart Disease	Diabetes	Cancer	Stroke	Alive	Died & Cause of Death	Age Died:
Mother									
Father									
Siblings									

Alcohol Use: ☐ Yes ☐ No **Type of alcohol:** ☐ Beer ☐ Wine ☐ Liquor

Drinks per day: _____ Drinks per week: _____ Drinks per month: _____

Tobacco Use: ☐ Yes ☐ No Packs per Day: _____

How Long: _____ Quit date: _____

Type: ☐ Cigarettes ☐ Vape Pen ☐ Pipe ☐ Cigars ☐ Chewing Tobacco

Marijuana Use: ☐ Yes ☐ No How often: _____

Drug Use: ☐ Yes ☐ No Type: _____

Are you Pregnant? ☐ Yes ☐ No

Do you have kids? ☐ Yes ☐ No

How many? _____ **How old?** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____

REVIEW OF SYSTEMS: PLEASE INDICATE BELOW IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

General Health:

Overall health (check one): ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

Unintentional weight gain or loss	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Unusual Fatigue	☐ Yes	☐ No

Eyes and vision:

Eye disease or injury	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No

Ears, nose, throat

Sinus problems	☐ Yes	☐ No
Bad breath or bad taste	☐ Yes	☐ No
Voice changes	☐ Yes	☐ No

Heart and Cardiovascular

Chest pain	☐ Yes	☐ No
Chest pressure	☐ Yes	☐ No
Chest heaviness	☐ Yes	☐ No
Sudden heartbeat changes	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No

Respiratory

Frequent coughing	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Gastrointestinal

Heartburn	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Throwing up blood	☐ Yes	☐ No
Ulcer in stomach	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Pain in stomach	☐ Yes	☐ No

Genitourinary:

Frequent or painful urination	☐ Yes	☐ No
Burning with urination	☐ Yes	☐ No
Bleeding with urination	☐ Yes	☐ No

Muscles and Bones

Arthritis/joint pain/weakness	☐ Yes	☐ No
Cramping pain in calves	☐ Yes	☐ No

Neurologic

Frequent or recurrent headaches	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Numbness or Tingling	☐ Yes	☐ No

Integumentary

Psoriasis	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Rash	☐ Yes	☐ No
Blisters	☐ Yes	☐ No
Allergic Reactions	☐ Yes	☐ No

Psychiatric

Memory loss or confusion	☐ Yes	☐ No
Nervousness/anxiety	☐ Yes	☐ No

Endocrine

Thyroid problems	☐ Yes	☐ No
Heat or cold intolerance	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No

Hematologic/Lymphatic:

Anemia or low blood count	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Blood transfusion in past	☐ Yes	☐ No
How many units: _____		
When: _____		
Swollen lymph glands	☐ Yes	☐ No
Where: _____		

Kidney Problems:

Flank Pain:	☐ Yes	☐ No

Patient Signature: _____ **Date:** _____ **Time:** _____

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Patient Information/Label

Burn Clinic
Patient Questionnaire