



PATIENT HEALTH QUESTIONNAIRE

Please Print

Name _____ Date of Birth _____ Date _____

Allergies: _____

Medication: Prescription and Over the Counter

Medication _____	Dose _____	Medication _____	Dose _____
Medication _____	Dose _____	Medication _____	Dose _____
Medication _____	Dose _____	Medication _____	Dose _____
Medication _____	Dose _____	Medication _____	Dose _____
Medication _____	Dose _____	Medication _____	Dose _____
Medication _____	Dose _____	Medication _____	Dose _____

Past Medical History: Do you have or have you ever had: (check problem and add year it happened or was diagnosed)

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Skin Ulcers _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Alcohol Problem _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Chest Pain _____ | <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> or Epilepsy _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Stomach Ulcers _____ | <input type="checkbox"/> Thyroid Disease _____ | <input type="checkbox"/> Sexually Transmitted _____ |
| <input type="checkbox"/> Herpes _____ | <input type="checkbox"/> Eye Disease _____ | <input type="checkbox"/> Reflux Disease _____ | <input type="checkbox"/> Blood Clot in Legs _____ | <input type="checkbox"/> Disease _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Tick Disease _____ | <input type="checkbox"/> Blood Transfusion _____ | <input type="checkbox"/> Heart Murmur/
Rhythm Problem _____ |
| <input type="checkbox"/> Back Pain _____ | <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Broken Bone _____ | <input type="checkbox"/> Degenerative Arthritis _____ | <input type="checkbox"/> Rheumatoid Arthritis _____ |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Rheumatoid Arthritis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Bladder/Kidney _____ | <input type="checkbox"/> High Blood Pressure _____ | _____ |

When was your most recent cholesterol test: _____ Results _____

Females: Number of Pregnancies _____ Number of Living Children _____ Type of Birth Control _____

Date of Last Pap Smear _____ Normal? _____

Date of Last Mammogram _____ Normal? _____

Any Abnormal Pap? _____ If periods have stopped, when was that? _____

Physician Notes (do not mark): _____

Past Surgical and Procedure History: Check surgery or procedure and year it was done. Add procedure if not listed:

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Gallbladder Removed _____ | <input type="checkbox"/> Prostate Surgery _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tonsillectomy _____ | <input type="checkbox"/> Heart Surgery _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Upper Endoscopy _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Colonoscopy _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Ovaries Removed _____ | <input type="checkbox"/> Cardiac Stress Test _____ | <input type="checkbox"/> _____ |

Physician Notes (do not mark): _____

Immunizations: When did you have your last:

- Tetanus Shot _____ Influenza Shot _____ Pneumonia Shot _____

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Social History:

Health Habits: Do you smoke? Yes No How many years? _____

Did you smoke in the past? Yes No Date stopped _____ Number of Years _____ I have never smoked.

Do you use other tobacco products? Yes No What type/how much _____

Do you use alcohol? Yes No How many drinks a week? _____ Do you use marijuana? Yes No

Do you use recreational drugs? Yes No What type/how often _____

Exercise: Once a week Two to three times a week Four to five times a week Every day
 Light Moderate Heavy What type? _____

Diet: Quality of your food choices: Very Good Good Fair Poor
 Special diet? _____ How many meals do you eat out per week? _____

Occupation _____ Previous occupation if retired _____

Number in your household _____ Partner's Name _____

Children's Names/Ages _____

Do you wear seatbelts? Yes No Has or is anyone abusing you in any way? Yes No _____

Family History:

Relative:	Current Age	Age at Death	Health problems/cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Mother's Mother	_____	_____	_____
Mother's Father	_____	_____	_____
Father's Mother	_____	_____	_____
Father's Father	_____	_____	_____

Siblings: (Check Sister or Brother)

<input type="checkbox"/> Sister <input type="checkbox"/> Brother	_____	_____	_____
<input type="checkbox"/> Sister <input type="checkbox"/> Brother	_____	_____	_____
<input type="checkbox"/> Sister <input type="checkbox"/> Brother	_____	_____	_____
<input type="checkbox"/> Sister <input type="checkbox"/> Brother	_____	_____	_____

List any member of your family not listed above who has:

Diabetes	Emphysema	High Blood Pressure	Heart Disease	Cancer (what type)	Mental Health Problem
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Current Health: Circle any symptoms that you have had in the last 3 months:

- Sore Throat
- Chest Pain or Tightness
- Abdominal Pain
- Trouble Holding Your Urine
- Double Vision
- Trouble Breathing
- Heartburn
- Burning with Urination
- Blindness
- Wheezing
- Blood in Stool
- Urinate Frequently
- Runny Nose
- Cough
- Black Stools
- Pain in Joints
- Ringing in Ears
- Heart Palpitations
- Diarrhea
- Back Pain
- Ear Pain/Drainage
- Dizziness
- Constipation
- Arthritis
- Hard of Hearing
- Swelling in Legs
- Hemorrhoids
- Fever/Night Sweats
- Headache
- Leg Pain with Walking
- Excessive Thirst
- Rash
- Difficulty Swallowing
- Bruise Easily
- Weight Loss
- Lump in Breast
- Fainted/Passed Out
- Balance Problems
- Skin Sores
- Numbness