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| Patient Health Questionnaire | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_  Do you have any medication allergies? \_\_\_\_ Yes \_\_\_\_ No  If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Review of Systems:  To the best of your knowledge, do you now have or have you ever had the following: | |
| Yes No | Yes No |
| **CONSTITUTIONAL** | **MUSCULAR/SKELETAL** |
| Unexplained Chills ❒ ❒ | Curvature of the Spine ❒ ❒ |
| Unexplained Fever ❒ ❒ | Arthritis/Joint Pain ❒ ❒ |
| Significant Weight Gain ❒ ❒ | Difficulty Walking ❒ ❒ |
| Significant Weight Loss ❒ ❒ | **SKIN** |
| **EYES** | Bruise Easily ❒ ❒ |
| Double Vision ❒ ❒ | Psoriasis ❒ ❒ |
| Vision Problems ❒ ❒ | Eczema ❒ ❒ |
| **EAR/NOSE/THROAT** | **NEUROLOGIC** |
| Lack of Sense of Smell ❒ ❒ | Polio ❒ ❒ |
| Hearing Loss ❒ ❒ | Stroke ❒ ❒ |
| **CARDIAC** | Head Injury ❒ ❒ |
| High Blood Pressure ❒ ❒ | Numbness of Arm/Leg ❒ ❒ |
| Heart Attack ❒ ❒ | **PSYCHOLOGICAL** |
| Irregular Heart Rate ❒ ❒ | Depression ❒ ❒ |
| Pacemaker ❒ ❒ | Drug/Alcohol Dependency ❒ ❒ |
| Rheumatic Fever ❒ ❒ | Psychiatric Treatment ❒ ❒ |
| **RESPIRATORY** | **ENDOCRINE** |
| Asthma or Wheezing ❒ ❒ | Diabetes ❒ ❒ |
| Shortness of Breath ❒ ❒ | Thyroid Disorder ❒ ❒ |
| Chronic Cough ❒ ❒ | **HEMATOLOGIC/LYMPH** |
| Sleep Apnea ❒ ❒ | Anemia ❒ ❒ |
| **GI TRACT** | Swollen Glands ❒ ❒ |
| Liver Disease ❒ ❒ | Immune Disease/AIDS ❒ ❒ |
| Stomach Ulcer ❒ ❒ | Blood Clots ❒ ❒ |
| Chronic Heartburn ❒ ❒ | Pulmonary Emboli ❒ ❒ |
| Hiatal Hernia ❒ ❒ | **ALLERGY/IMMUNOLOGIC** |
| **GENITAL/URINARY** | Iodine ❒ ❒ |
| Urinary Tract Infection ❒ ❒ | Shellfish ❒ ❒ |
| Kidney of Bladder Disease ❒ ❒ | Latex ❒ ❒ |
| Difficulty Urinating ❒ ❒ |  |

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| SOCIAL HISTORY |
| Do you smoke? \_\_\_\_ Yes \_\_\_\_ No (Number of packs/day \_\_\_\_ for \_\_\_\_ years)  Do you drink? \_\_\_\_ Yes \_\_\_\_ No (Number of drinks/week \_\_\_\_)  Are you married \_\_\_\_ Yes \_\_\_\_ No Do you live alone? \_\_\_\_ Yes \_\_\_\_ No  Level of Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PAST HISTORY |
| Any medical history not covered in previous questions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you pregnant or think you may be? \_\_\_\_ Yes \_\_\_\_ No  Surgeries/Hospitalization Reason Year  1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication that you are currently taking:  Medication Dosage When you started taking  1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |