PATIENT HEALTH QUESTIONNAIRE

NAME:_________________________________AGE:________DATE:________________________

REFERRING DOCTOR:____________________PRIMARY CARE DOCTOR:_________________

Describe why you are seeing the doctor today: ____
What type of work do you do? __________________________________Marital Status: S M D W

Do you use tobacco products or smoke? _______ If so, how much per day? _____________________
How long have you smoked? ____________ Have you ever smoked? ________ If so, when did you quit?
____________ Do you drink alcohol? ______ If so, how much / how often? ________________

Are you allergic to any medications? YES / NO Please list them and type of reaction you have:
____
____

Please list all surgeries you have had:

OPERATION	**DATE**
____	__________________________________
____	__________________________________
____	__________________________________
____	__________________________________

Have you ever had any of the problems or illnesses listed below? If so, please explain:

CONDITION	**YES / NO**	**COMMENTS**
*Stroke, numbness or weakness on one side of your body	__________	__________________________________
*Loss of vision in one eye (temporary or permanent)	__________	__________________________________
*Heart attack	__________	__________________________________
*Chest pains	__________	__________________________________
*Congestive heart failure	__________	__________________________________
*Heart murmur	__________	__________________________________
*Other heart problems	__________	__________________________________
*High blood pressure	__________	__________________________________
*Increased cholesterol	__________	__________________________________

CONDITION	YES / NO	COMMENTS
*Diabetes	________	________
*Pain in the legs while walking	________	________
*Blood clots in veins / phlebitis	________	________
*Asthma / wheezing	________	________
*Shortness of breath	________	________
*Pneumonia	________	________
*Other lung problems	________	________
*Stomach ulcers	________	________
*Jaundice / hepatitis	________	________

	YES / NO	COMMENTS
*HIV / AIDS	________	________
*Gallbladder disease or stones	________	________
*Other digestive problems	________	________
*Anemia, fever, weight change	________	________
*Blood in stools	________	________
*Bleeding problems, bruising problems	________	________
*Nosebleeds	________	________
*Epilepsy	________	________
*Thyroid disease	________	________
*Kidney disease or stones	________	________
*Urinary problems / infections	________	________
*Arthritis / broken bones	________	________
*Other bone / joint problems	________	________
*Any other medical problems	________	________

FAMILY MEDICAL HISTORY

FAMILY MEMBER	ALIVE / DECEASED	STATE OF HEALTH / CAUSE OF DEATH
Father	________	________
Mother	________	________
Brothers / Sisters	________	________
	________	________
	________	________
	________	________

FEMALE PATIENTS ONLY

Could you be pregnant now? ________________ Date of last menstrual period ____________________