# PATIENT HEALTH QUESTIONNAIRE

NAME: First Middle Last
_______________________________________________

Date of Birth ____________________

Today's Date ______________

**DRUG ALLERGIES OR REACTIONS** ______________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Occupation: ________________________________

Marital Status: _____________________________

**MEDICAL HISTORY** (List illness/surgery and dates)

| CHRONIC ILLNESSES HOSPITALIZATION OR PREVIOUS MAJOR SURGERIES | |
|---|---|
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| | |

Please check if you have or have had the following:

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ HEART DISEASE ☐ LUNG PROBLEMS

☐ BLOOD CLOTS ☐ SEIZURES ☐ DEPRESSION / ANXIETY ☐ CANCER. Type______________

| **FAMILY HISTORY** | AGE IF LIVING | AGE AT DEATH | PRESENT CONDITION OR CAUSE OF DEATH |
|---|---|---|---|
| FATHER | | | |
| MOTHER | | | |
| BROTHERS | | | |
| | | | |
| NUMBER ________ | | | |
| SISTERS | | | |
| | | | |
| NUMBER ________ | | | |
| CHILDREN | | | |
| | | | |
| NUMBER ________ | | | |

**HAS ANY RELATIVE HAD THE FOLLOWING:**

- ☐ Alcoholism ________________
- ☐ Alzheimer's ________________
- ☐ Anemia/Low Blood Count ________________
- ☐ Lung Problems ________________
- ☐ Cancer, Breast ________________
- ☐ Cancer, Colon ________________
- ☐ Cancer, Prostate ________________
- ☐ Cancer, Other ________________
- ☐ Heart Disease ________________
- ☐ Depression ________________
- ☐ Bipolar Disorder ________________
- ☐ Diabetes ________________
- ☐ Blood Clots ________________
- ☐ Hearing Loss ________________
- ☐ High Blood Pressure ________________
- ☐ High Cholesterol ________________
- ☐ Osteoporosis ________________
- ☐ Stroke ________________
- ☐ Other ________________

**PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, AND HERBAL SUPPLEMENTS:**

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Are you taking aspirin daily? ☐ Yes ☐ No

Birth Control Method: ______________

Do you have any objections to a blood transfusion? ☐ Yes ☐ No

**Immunization Shots**

Dates of Last: Flu_______ Tetanus_______ Pneumonia_______ Hep A _______ Hep B _______

**SOCIAL HISTORY**

| EXERCISE: | SMOKING: | ALCOHOL: | RECREATIONAL DRUGS Y N |
|---|---|---|---|
| Type _______________ | Packs per day _____ | Drinks per day _____ | |
| _______________ | No of years _____ | Drinks per week _____ | |
| _______________ | Year stopped _____ | | |
| How often? ____________ | ☐ Pipe ☐ Cigar ☐ Chew | Alcohol problem: ☐ Yes ☐ No | |

**PLEASE CHECK ALL THAT APPLY AND/OR WRITE IN OTHER PROBLEMS.**

**GENERAL HEALTH** [ ] Fatigue [ ] Weakness [ ] Weight loss [ ] Ankle swelling [ ] Sleep problems
[ ] No problems [ ] Other ____________________

**MENTAL HEALTH** [ ] Memory problems [ ] Depressed [ ] Tense, nervous
[ ] No problems [ ] Other ____________________

**BRAIN AND NERVES** [ ] Fainting [ ] Poor balance [ ] One or more falls in past 6 months
[ ] No problems [ ] Other ____________________

**URINARY** [ ] Leaking bladder [ ] Difficulty urinating [ ] Sexual difficulty or concern
[ ] No problems [ ] Other ____________________

**BONES AND MUSCLES** [ ] Difficulty or pain with walking [ ] Painful joints
[ ] No problems [ ] Other ____________________

**HEAD AND NECK** [ ] Hearing problem [ ] Eyesight problem
[ ] No problems [ ] Other ____________________

**BREATHING** [ ] Cough [ ] Short of breath
[ ] No problems [ ] Other ____________________

**HEART** [ ] Chest pain or pressure [ ] Irregular heart beat [ ] Leg pain with walking
[ ] No problems [ ] Other ____________________

**STOMACH AND BOWELS** [ ] Swallowing trouble [ ] Indigestion [ ] Abdominal pain
[ ] Constipation [ ] Diarrhea [ ] Blood in stool or black stools
[ ] No problems [ ] Other ____________________

**SKIN** [ ] Rash [ ] Skin problems [ ] Skin cancer
[ ] No problems [ ] Other ____________________

**Other** [ ] Gonorrhea [ ] Herpes [ ] Chlamydia

**WOMEN ONLY** [ ] Abnormal Vaginal bleeding [ ] Vaginal Discharge [ ] Abnormal pap
[ ] Hot Flashes [ ] Breast lump [ ] Breast pain
[ ] No problems [ ] Other ____________________

**Date of Last:** Mammogram ____________ Pap Smear____________ DEXA Scan____________

Colonoscopy____________ Abnormal Results? ____________

Patient/Family Member____________________ Date____________

Please print patient name____________________ Date of Birth____________