Patient Health Questionnaire

Name_________________________________ Date______________

DOB_____________ Age_______ New Patient____ Established___

PLEASE NOTE: **This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.**

What medical concerns bring you to our office? ____

What is your primary language? ______________________

Do you have special needs in any of the following areas?

☐ Reading ☐Vision ☐ Hearing ☐Mobility (e.g., wheelchair, walker, etc.) ☐Communication (e.g., need for translator)

Marital Status: *(circle)* S M D W Occupation: *(if retired, previous occupation)* ______________________________

If disabled, check here: _____Nature of disability ______________________________ Birthplace: _____________

Have you completed Advanced Directives or do you have a Living Will? *(circle)* No Yes Which? _________________

Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt., etc.)*

____

Are you under a lot of pressure at work or at home? *(circle)* No Yes, Which? ________________________________

Medical Information

Allergies: Are you allergic to any drugs? *(Circle)* No Yes Please list.______________________________________

____

Medications *(list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)*

_____________________ _____________________ _____________________

_____________________ _____________________ _____________________

_____________________ _____________________ _____________________

_____________________ _____________________ _____________________

What pharmacy do you use?____

Name___________________________

YOUR MEDICAL CONDITIONS (check all that apply)

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Asthma
☐ Blood transfusion
☐ Cancer
☐ Clotting disorder
☐ Congestive heart failure
☐ Depression
☐ Diabetes mellitus
☐ Emphysema/COPD
☐ Gastroesophageal reflux disease (GERD)
☐ Glaucoma
☐ Heart murmur
☐ HIV/AIDS
☐ High cholesterol
☐ Hypertension/high blood pressure
☐ Kidney disease
☐ Myocardial infarction
☐ Nerve/muscle disease
☐ Osteoporosis
☐ Seizures
☐ Sickle cell anemia
☐ Substance abuse
☐ Thyroid disease
☐ Tuberculosis
☐ Other_____________________

YOUR SURGICAL HISTORY (check all that apply)

☐ Appendectomy
☐ adder surgery
☐ Bunionectomy
☐ Brain surgery
☐ Breast surgery
☐ CABG
☐ Cholecystectomy
☐ C-section
☐ Cardiac stent
☐ Eye surgery
Herni ☐
☐ Fracture surgery
☐ Hysterectomy
☐ Joint surgery
☐ Lung surgery
☐ Prostate surgery
☐ Small intestine surgery
☐ Spine Surgery
☐ Thyroid surgery
☐ Tonsillectomy&Anoids
☐ Tubal ligation
Valve ☐ eplacement
☐ Varicose vein surgery
☐ Vasectomy
☐ Vascular surgery
☐ Weight reduction surgery
☐ Other_________________

FAMILY HISTORY (check all that apply)

	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Other Cancers	Diabetes	Heart Disease	High Cholesterol	Hypertension	Mental illness
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Other relative										

Other family history____

HABITS AND ACTIVITIES

Do you use tobacco? ☐ No ☐ Yes, what form?______________ How much? ______________ For how long? ________
☐ In the past How many years ago did you quit_____________________________
☐ Have you tried to quit? ☐ No ☐ Yes Would you like to quit? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ In the past ☐ Yes, how many drinks per week? ____________________________________
Do you, or have you ever used recreational drugs? ☐ No ☐ Yes, describe: ______________________________________
Do you get regular exercise? ☐ No ☐ Yes, what kind of exercise? ____
How often? ______________________________ List any hobbies or leisure activities____________________________
____

Name___________________________

IMMUNIZATIONS

Vaccination	Approximate Date	Never
Pneumonia (pneumovax)	____________________________________	☐
Tetanus booster (Tdap)	____________________________________	☐
TB skin test	____________________________________	☐
Hepatitis A vaccine	____________________________________	☐
Hepatitis B vaccine	____________________________________	☐
Varicella (chicken pox)	____________________________________	☐
Shingles	____________________________________	☐

PREVENTIVE CARE

Test or Procedure	Approximate Date	Never
Colonoscopy	____________________________________	☐
Bone density	____________________________________	☐
Cholesterol test	____________________________________	☐
PSA (prostate cancer)	____________________________________	☐
Pap smear	____________________________________	☐
Mammogram	____________________________________	☐
HIV test	____________________________________	☐

List any abnormal screening test results (e.g. polyps, breast biopsies, etc.):_______________________________________

____

SEXUAL HISTORY

My sexual partners have been: ☐Male ☐Female ☐Both ☐Never Sexually Active

Have you had more than one sexual partner in the past year? ☐ No ☐Yes

Have you ever had a sexually transmitted disease? ☐ No ☐Yes, what and when? ________________________________

GYNECOLOGICAL AND OBSTETRIC HISTORY (Females only)

How many times have you been pregnant? ______ Live births? _______Miscarriages? ________ Abortions___________

Do you use contraception? ☐No ☐Yes, what kind ____

What was your age at first menses? _________ Menstrual periods: ☐Regular ☐Irregular ☐Menopausal

Age at menopause? _____ Do you have hot flashes or other symptoms (specify)? _________________________________

Any gynecological conditions or problems? ____

OTHER HEALTH ISSUES

Do you feel unsafe or have you have harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? ☐No ☐Yes, describe: ____

In the past year, have you had two weeks or more during which you felt sad, blue or depressed or when you have lost all interest or pleasure in things that you usually care about or enjoyed? ☐No ☐Yes, describe_________________________

____

In the past year, have you had any major life changes or stress that you feel have impacted your overall health?

☐No ☐Yes, describe:____

____

Name: ______________________________ DOB: ______________________________

Systems Review: Please indicate those items that have been a recurrent or a recent significant change.

Yes	No	
		Constitutional Symptoms
____	____	Good health lately
____	____	Recent significant weight change
____	____	Unusual fatigue or weakness
____	____	Frequent headaches
		Eyes
____	____	Change in vision
____	____	Blurred or double vision
____	____	Eye disease or injury
____	____	Wear glasses/contact lenses?
		Ears/Nose/Mouth/Throat/Neck
____	____	Do you wear hearing aids?
____	____	Hearing loss or ringing in ears?
____	____	Earaches or drainage?
____	____	Chronic sinus problems or runny nose
____	____	Nose bleeds
____	____	Mouth sores
____	____	Bleeding gums
____	____	Sore throat/hoarseness or voice change
____	____	Lumps or swollen glands in neck
____	____	Difficulty swallowing
____	____	Neck pain or stiffness
		Cardiovascular
____	____	Heart trouble
____	____	Chest pain or angina pectoris
____	____	Palpitations
____	____	Shortness of breath with walking or lying flat
____	____	Swelling feet, ankles or hands
____	____	Waking at night with shortness of breath
		Respiratory
____	____	Chronic or frequent cough
____	____	Coughing or spitting up blood
____	____	Shortness of breath
____	____	Asthma or recurrent wheezing
		Gastrointestinal
____	____	Loss of appetite
____	____	Change in bowel movements
____	____	Nausea or vomiting
____	____	Painful bowel movements or constipation
____	____	Frequent diarrhea
____	____	Rectal bleeding or blood in stool
____	____	Stomach/abdominal pains or heartburn
____	____	Black or tarry stools
		Psychiatric
____	____	Memory loss
____	____	Nervousness
____	____	Insomnia
____	____	Depression

Yes	No	
		Genitourinary
____	____	Frequent urination
____	____	Burning or pain on urination
____	____	Blood in urine
____	____	Change in force or strain when urinating
____	____	Incontinence or dribbling of urine
____	____	Sexual difficulties
____	____	Men: Testicular pain
____	____	Women: Painful periods
____	____	Irregular periods
____	____	Recurrent vaginal discharge
		Musculoskeletal
____	____	Joint pain(s)
____	____	Joint stiffness/swelling or warmth
____	____	Weakness of muscles or joints
____	____	Muscle pain or recurrent cramps
____	____	Back pain
____	____	Cold hands or feet
____	____	Difficulty in walking
	Integumentary (Skin/Breast)	
____	____	Rashes or itching
____	____	Change in skin color or moles
____	____	Change in hair or nails
____	____	Varicose veins
____	____	Breast pain
____	____	Breast lump
____	____	Breast discharge or rash
		Neurological
____	____	Frequent, recurring or increasing headaches
____	____	Light-headedness or dizziness
____	____	Convulsions, seizures or spasms
____	____	Numbness or tingling sensations
____	____	Tremors
____	____	Paralysis
____	____	Stroke
____	____	Head injury
		Endocrine
____	____	Glandular or hormone problem
____	____	Heat and cold intolerance
____	____	Excessive skin dryness
____	____	Excessive thirst or urination
____	____	Change in hand or glove size
		Hematologic/Lymphatic
____	____	Slow to heal after cuts or wounds
____	____	Bleeding or bruising tendency
____	____	Recurrent anemia
____	____	Swelling, warmth or tenderness of veins or history of phlebitis