



# Patient Health Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician/PCP: \_\_\_\_\_

## Reason for visit today

### Past Medical History

- Heart failure
- Heart attack
- Irregular heart beat
- Heart murmur
- Antibiotics before dental work
- High blood pressure
- Diabetes
- High Cholesterol
- COPD/Emphysema/Asthma
- Hypo/Hyperthyroid
- Clotting disorder
- Sleep Apnea
- DVT/PE

*if you have a history of any problems listed below*

- Anemia
- Ulcers
- Colon cancer
- Colon polyps
- Hepatitis
- Ulcerative Colitis
- Crohn's Disease
- Irritable/spastic bowel
- GERD/Reflux
- Breast cancer
- Prostate cancer
- Uterine cancer

- Kidney disease/Dialysis
- Tuberculosis/PPD
- HIV/AIDS
- Arthritis/Rheumatoid
- Stroke
- Seizure Disorder
- Depression
- Anxiety
- Endometriosis
- Blood Transfusion
- Other cancer \_\_\_\_\_
- Other \_\_\_\_\_

### Past Surgical History

*Check if you have had any of the surgeries below and list year of your surgery*

- Gallbladder removal \_\_\_\_\_
- Appendectomy \_\_\_\_\_
- Colon or bowel resection \_\_\_\_\_
- Ulcer surgery \_\_\_\_\_
- Artificial Joint \_\_\_\_\_
- Heart bypass \_\_\_\_\_
- Artificial heart valve \_\_\_\_\_
- Upper Endoscopy \_\_\_\_\_
- Other \_\_\_\_\_

- Mastectomy/Lumpectomy \_\_\_\_\_
- Hysterectomy \_\_\_\_\_
- Ovary removal \_\_\_\_\_
- C-Section \_\_\_\_\_
- Tubal ligation \_\_\_\_\_
- Hernia Repair \_\_\_\_\_
- Hemorrhoid removal \_\_\_\_\_
- Colonoscopy \_\_\_\_\_
- Other \_\_\_\_\_

### Current Medications

*Include prescription, over the counter, home and herbal remedies*

_____	_____
_____	_____
_____	_____
_____	_____

### Medication Allergies

*Include type of reaction*

No known allergies

\_\_\_\_\_

### Family Medical History

*Check if a blood relative has had a history of any problem listed below*

- Heart Disease
- High Blood Pressure
- Diabetes
- Breast Cancer
- Uterine Cancer
- Other \_\_\_\_\_

- Colon Cancer
- Colon Polyps
- Ulcers
- Ulcerative Colitis
- Crohn's Disease
- Stomach Cancer

- Liver Disease
- Pancreatic problem
- Gallbladder problem
- Anemia
- Other \_\_\_\_\_
- Other \_\_\_\_\_



**Social History**

Smoking: None now None ever  
 Currently how many/day? \_\_\_\_\_ # of years? \_\_\_\_\_  
 In past how many/day? \_\_\_\_\_ # of years? \_\_\_\_\_  
 When did you quit? \_\_\_\_\_

Alcohol: None now None ever  
 How many cocktails/beer/wine \_\_\_\_\_ daily/weekly/monthly/yearly (Circle one)

Cups of coffee/day \_\_\_\_\_ Caffeinated soft drinks/day \_\_\_\_\_

History of recreational drug use? None IV drugs \_\_\_\_\_ Intranasal \_\_\_\_\_ Other \_\_\_\_\_

Occupation \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Domestic partnership

Children ages and health \_\_\_\_\_

**Review of Systems** *Check symptoms you are currently having or have had in the last 3 months*

- Fatigue
- Weight loss-unintended
- Weight gain
- Fever
  
- Rash
- Itching
- Jaundice/Yellowing of eyes
  
- Swelling in neck
- Sores in mouth
- Ringing in ears
- Vertigo
- Difficulty hearing
- Nose bleeds
- Pain in throat
- Hoarseness
- Glaucoma/Cataracts
  
- Cough
- Shortness of breath
  - with exertion
  - when laying down
  - at night when sleeping
- Wheezing
  
- Chest pain
- Swelling in legs
- Pain in calf when walking

- Nausea
- Vomiting
- Loss of appetite
- Heartburn
- Pain when swallowing
- Food sticking in chest
- Abdominal pain
  - after eating
  - before eating
  - at night
- Abdominal bloating/swelling
- Diarrhea
  - at night
- Constipation
- Blood in stool
- Oily stools
- Rectal pain/pressure
- Leakage of stool
  
- Loss of bladder control
  - when coughing/laughing
- Burning with urination
- Frequent urination
- Blood in urine
- Urinating at night
  
- Easy bruising

- Men:
  - Slow urine stream
  - Difficulty with erection
- Women:
  - Last period \_\_\_\_\_
  - Irregular periods
  - Heavy menstrual bleeding
  - Painful intercourse
- Joint pain/swelling
- Nervousness
- Depression
- Insomnia
  
- Blackouts
- Headaches
- Difficulty speaking
- Tremors
  
- Loss of body hair
- Increased thirst
- Heat or cold intolerant
  
- Other \_\_\_\_\_
- Other \_\_\_\_\_
  
- All others negative

Patient signature \_\_\_\_\_ MD/PA signature \_\_\_\_\_