PATIENT HEALTH QUESTIONNAIRE (pg 1)

Patient Name _____ Today's Date _____

(please print)

MAIN REASON FOR TODAY'S VISIT:

_____

PRIMARY CARE PHYSICIAN (PCP): _____

MEDICAL HISTORY: Childhood / Adult Illness (check all that apply)

[ ] Kidney Disease _____ years	[ ] Stroke – year ___	[ ] High Blood Pressure - ___ years
[ ] Cancer – type _____	[ ] Diabetes _____ years	[ ] Asthma
[ ] Heart Disease _____ years	[ ] Ulcer	[ ] Kidney Stones – latest _____
[ ] Ankle and / or feet swelling	[ ] Gout - _____ years	[ ] Arthritis

[ ] Other _____

Serious Injuries / Illnesses / Medical Problems (i.e. cancer, heart disease, high blood pressure, pneumonia)

_____

_____

_____

Previous Hospitalizations and Surgeries

_____

_____

Known Allergies to Medicine (please list)

_____

CURRENT MEDICATIONS: List your current prescribed medications, over-the-counter non-prescription medications including vitamins, herbs, and inhalers: (continue on back if needed).

Name of Drug:	**Strength:**	**Frequency Taken:**

ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

CONSTITUTIONAL SYMPTOMS

Unexplained weight gain or loss ..... Yes No
Fever or chills ..... Yes No
Night sweats/Hot flashes ..... Yes No
Fatigue ..... Yes No

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency ..... Yes No
Anemia ..... Yes No

EYES

Blurred or double vision ..... Yes No

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing ..... Yes No
Earaches or drainage ..... Yes No
Chronic sinus problem or rhinitis ..... Yes No
Recurrent nose bleeds ..... Yes No
Bleeding gums ..... Yes No
Sore throat or voice change (hoarseness). Yes No
Hay fever ..... Yes No

CARDIOVASCULAR

Heart trouble ..... Yes No
Chest pain or angina pectoris ..... Yes No
Palpitation (fast or irregular heart beat) .. Yes No
Shortness of breath while walk/lying flat . Yes No
Swelling of feet, ankles or hands ..... Yes No
High blood pressure ..... Yes No

RESPIRATORY

Chronic or frequent coughs ..... Yes No
Spitting up blood ..... Yes No
Shortness of breath ..... Yes No
Asthma or wheezing ..... Yes No

GASTROINTESTINAL

Loss of appetite ..... Yes No
Change in bowel movements ..... Yes No
Nausea or vomiting ..... Yes No
Frequent diarrhea ..... Yes No
Painful bowel movements or constip..... Yes No
Rectal bleeding or blood in stool ..... Yes No
Abdominal pain or heartburn ..... Yes No
Peptic ulcer (stomach or duodenal) ..... Yes No
Trouble swallowing ..... Yes No

GENITOURINARY

Frequent urination .....Yes No
Burning or painful urination .....Yes No
Blood in urine .....Yes No
Urination at night (> 1/night)? .....Yes No
Incontinence or dribbling ..... Yes No
Decrease in urine stream ..... Yes No
Kidney stones ..... Yes No
Sexual difficulty ..... Yes No
Slow to start/stop urination ..... Yes No
Female – pain with periods ..... Yes No
Female – irregular periods ..... Yes No
Female – Contraception type _____
Female – Days in menstrual cycle _____
Female – Date of last menstrual period _____

MUSCULOSKELETAL

Joint pain ..... Yes No
Joint stiffness or swelling ..... Yes No
Back pain ..... Yes No

INTEGUMENTARY (skin, breast)

Rash or itching ..... Yes No
Breast pain ..... Yes No
Breast lump ..... Yes No
Breast discharge ..... Yes No

NEUROLOGICAL

Frequent or recurring headaches ..... Yes No
Lightheaded or dizzy ..... Yes No
Convulsions or seizures ..... Yes No
Numbness or tingling sensations ..... Yes No
Paralysis ..... Yes No
Memory loss or confusion ..... Yes No

ENDOCRINE

Thyroid disease ..... Yes No
Diabetes ..... Yes No
Other glandular or hormone problem Yes No

OTHER

Nervousness ..... Yes No
Depression/Anxiety/Panic ..... Yes No
Insomnia ..... Yes No

Other concerns not noted above:

_____
_____
_____
_____

PATIENT SOCIAL HISTORY (continued pg3)

Children: _____ Number of children

Liquid Intake:

Alcohol: [ ] Never [ ] Rarely [ ] Moderate [ ] Daily _____(quantity)

Caffeine (cups per day): [ ] Coffee - _____ [ ] Soda - _____ [ ] Tea - _____

Water Intake: Number of Cups per day - _____

Tobacco Use: [ ] Never [ ] Previously, but quit _____ [ ] Current pack(s) / day - _____

Drug Use: [ ] Never [ ] Current or previous use (type/frequency) _____

Exercise: [ ] Never [ ] Rarely [ ] Weekly [ ] Daily Type of Exercise: _____

Salt Intake: [ ] High [ ] Medium [ ] Low

Fat Intake: [ ] High [ ] Medium [ ] Low

FAMILY MEDICAL HISTORY: Do you know any blood relatives who have or had (indicate relationship):

Kidney Disease: _____ High Blood Pressure _____

Cancer: _____ Osteoporosis: _____

Diabetes: _____ Heart Disease: _____

Genetic Disorder: _____ Stroke: _____

Gout: _____