PATIENT HEALTH QUESTIONNAIRE Patient Name _____

(please print)

MAIN REASON FOR TODAY'S VISIT: Today's Date _____

_____

MEDICAL HISTORY

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

_____

_____

_____

Previous Hospitalizations and Surgeries

_____

_____

Medications/Vitamins_____

_____

Known Allergies to Medicine (please list)

_____

FOR WOMEN ONLY:

# of pregnancies_____ # of miscarriages_____ # of abortions_____ Age at 1st menstrual cycle?_____

Age at menopause_____ Date of last pap smear_____ Date of last mammogram_____

PATIENT SOCIAL HISTORY

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Current Occupation: _____ Sexual Orientation (optional) _____

Use of Alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of Caffeine, Cups per Day: Coffee _____ Sodas _____ Tea _____

Use of Tobacco: Never _____ Previously, but quite _____ Current packs/day _____

Use of Drugs: Never _____ Type/Frequency _____

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

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

Arthritis _____ High Blood Pressure _____

Asthma/Allergies_____ Mental Illness _____

Cancer _____ Osteoporosis _____

Diabetes _____ Premature Menopause _____

Genetic Disorder_____ Stroke _____

Heart Disease _____ Thyroid Disorder _____