Patient Health Questionnaire

Patient Name:	
Today's Date: / /	Date of Birth: / /
Reason for Today's Visit:	

Social History

Marital Status	Single Married Divorced Widowed	
Alcohol Use	Yes / No	If yes, number of drinks per week:_____
Tobacco Use	Yes / No	If yes, type and frequency:_____
Exercise	Yes / No	If yes, type and frequency:_____
Disability	Yes / No	If yes, type of disability:_____

Past Medical History

Have you ever had or been diagnosed to have (*check all that apply*):

	Allergies		Anemia		Anxiety		Arthritis		Asthma
	Bleeding Disorder		Bone Disorder		Cancer		Cataracts		Depression
	Diabetes		Digestive Disorder		Glaucoma		Heart Attack		Heart Disease
	Heart Murmur		Hemorrhoids		High Blood Pressure		High Cholesterol		Kidney Disease
	Kidney Stones		Liver Disease		Measles		Pneumonia		Prostate Disorder
	Seizure/Epilepsy		STD		Stroke		TB/Lung Disease		Thyroid Disease
	Ulcer		Alzheimer's						

Medications & Dosage

List all prescription and OTC medications (*including dosage*) that you are currently taking:

Allergies

Do you have any known allergies? If so, please list/describe:

Past Surgical History

Please list any surgical procedures you have undergone:

Year	Surgery/Procedure

Family Medical History

	Age	Health	Age at Death	If deceased, cause	Comments
Father					
Mother					
Siblings					

Has any blood relative ever been diagnosed with any of the following conditions?

	Alzheimer's		Heart Attack		Alcoholism		Tuberculosis		Bleeding Disease
	Mental Disorder		Diabetes		Stroke		Heart Disease		Cancer

Reproductive History (Females Only)

Number of Children:	Last Menstrual Period:
Hysterectomy? Yes / No If yes, when:	Birth Control:

Review of Systems

Please indicate those items that you are currently experiencing or have recently experienced:

	Weight Change		Vision Change		Blurred Vision		Hearing Aides		Hearing Loss
	Sinus Problem		Nose Bleed		Chest Pain		Heart Palpitations		Shortness of Breath
	Cough		Asthma		Loss of Appetite		Nausea		Vomiting
	Fever		Diarrhea		Constipation		Frequent Urination		Pain w/ Urination
	Incontinence		Joint Pain		Weakness of muscle		Back pain		Change in skin color or moles
	Rash		Breast Lump		Headaches		Numbness		Tremors

Is there anything else you feel the doctor should know about you and/or your medical history?