Patient Health Questionnaire

Name Date Birth date Age

PRESENT HEALTH CONCERNS

Health Concern	Has this been diagnosed?	Who is treating this?	Is this stable?

ALLERGIES

Drugs _____ Foods _____

Environmental _____

What are your symptoms during an allergy attack? _____

_____

Sensitivities: ❒ Perfumes ❒ Cigarette smoke ❒ Cleaning supplies ❒ Other: _____

Past history of long-term antibiotic use? ❒ **Y** ❒ **N** How long? _____

Past history of long-term corticosteroid use? ❒ **Y** ❒ **N** How long? _____

Current Medications	Dose	Times/Day
Current Herbs/Vitamins/Supplements	**Dose**	**Times/Day**

HEALTHCARE PROVIDERS	Provider/Group Name	Last Seen (month/year)
PCP		
OB/GYN		
Dentist		
Optometrist		
Other		

IMMUNIZATIONS

❒ Immunizations are ALL up to date.

OR check those received: ❒ MMR ❒ DTaP ❒ HepB ❒ Rota ❒ Hib ❒ Polio ❒ Pneumococcal ❒ Varicella ❒ Hep A ❒ Meningococcal ❒ HPV ❒ Tetanus ❒ Hepatitis A / B ❒ Flu Shot ❒ Other: _____

Have you had a TB test in the last year? ❒ Y ❒ N **Have you ever tested positive for TB?** ❒ Y ❒ N

Please list any childhood illnesses: _____

Please list prior illness, injury, hospitalization, surgery, and/or trauma _____

Reason: _____ Date: _____

(continued)

HEALTH SCREENING HISTORY	Date of most recent	HEALTH SCREENING (CONT)	Date of most recent
Mammogram		Test for Blood in Stool	
Pap Smear		Rectal Exam	
Self Breast Exam		Lower Bowel Scope (if over 50)	
Professional Breast Exam		Blood Work (other)	
Self Testicle Exam		Cholesterol	
Professional Testicle Exam		Blood Sugar	
Professional Prostate Exam		Hepatitis C Screening (if over 50)	

PERSONAL/FAMILY HISTORY

	SELF	MOTHER	FATHER	SIBLINGS	OTHER (please specify)*
Age (if living)					
Age (at death)					
Cause of death					
Health; **G** = good, **P** = poor					
Check those applicable					
Alcoholism/Substance Abuse					
Allergies/Hay Fever/ Asthma					
Anemia					
Bleeding Disorder					
Cancer or Tumor					
Chronic Fatigue					
Diabetes					
Epilepsy					
Glaucoma					
Genetic Disease					
Heart Disease					
Hepatitis					
Herpes					
High Blood Pressure					
High Cholesterol					
Kidney or Bladder Trouble					
Mental or Nervous Disorder					
Rheumatism/Arthritis					
Stomach/Ulcer					
Stroke					
Thyroid Disorder					
Tuberculosis					
Other (specify)					

* MGM (Maternal Grandmother), MGF (Maternal Grandfather), PGM, PGF, Aunt(s), Uncle(s)

(continued)

Do You Use or Have Any of these Devices? ❒ Brace (Neck, Back) ❒ Pacemaker ❒ Metal implants ❒ IUD
❒ Artificial Limbs ❒ Other: _____

TRAVEL HISTORY: (out of US; epidemic areas) _____
_____

SOCIAL HISTORY (check all that apply)

	Marital Status		Education Completed		Childhood Memories		Do You Find Your Life
	Single		High School		Mostly Happy		Generally Unsatisfactory
	Married		College		Mostly Painful		Too Demanding
	Divorced		Professional School		Normal		Boring
	Widowed		Other:		Don't Recall		Satisfactory/Great

Living arrangement: ❒ Alone ❒ Family ❒ Roommate ❒ Spouse/Partner
❒ Children (list sex/ages): _____
Major stresses in last 12 months: ❒ Money ❒ Job ❒ Marriage ❒ Home Life ❒ Children
❒ Other stressors _____
Rate your stress level out of 10 on average (10 worst stress): _____ Is this a change? ❒ Y ❒ N

Do you smoke cigarettes? ❒ Y ❒ N If yes, how many? #___ yrs. _____ packs per day
Did you ever smoke? ❒ Y ❒ N If yes, when did you quit? _____
Do you drink alcohol? ❒ Y ❒ N If yes, how much? Type_____ & ___ drinks per week
Do you drink caffeinated beverages? ❒ Y ❒ N If yes, which, how much? _____
Do you use recreational drugs? ❒ Y ❒ N If yes, which? _____
Do you exercise regularly? ❒ Y ❒ N If no, why? _____
If yes, what types of exercise? _____

frequency of exercise:
❒ 5 -7 days/wk
❒ 3-4 days/wk
❒ 1-2 days/wk

duration of workout:
❒ 45 minutes or more duration per workout
❒ 30-45 minutes or more duration per workout
❒ Less than 30 minutes

Do you sleep soundly and wake rested? ❒ Y ❒ N If no, why?_____
Do you manage stress well? ❒ Y ❒ N ❒ NOT SURE ❒ NEED HELP
Is your diet satisfying? ❒ Y ❒ N
Do you consider your diet healthy? ❒ Y ❒ N ❒ NOT SURE ❒ NEED HELP

Dietary restriction or regimen? ❒ mixed food diet (animal and vegetable sources) ❒ vegetarian ❒ vegan
❒ salt restriction ❒ fat restriction ❒ starch/carb restriction ❒ total calorie restriction
Cravings? ❒ starches ❒ sweets ❒ salt ❒ fats other: _____
What diets have you been on? ❒ Atkins ❒ South Beach ❒ Blood Type ❒ Weight Watchers Oth-
er:_____
Specific food restrictions? ❒ dairy ❒ wheat ❒ eggs ❒ soy ❒ all gluten ❒ carbs/sugar
How much water do you drink per day? _____ Do you get sleepy in the afternoon? ❒ Y ❒ N
Eating habits: ❒ skip meals ❒ one meal/day ❒ two meals/day ❒ three meals/day
❒ graze (small frequent meals) ❒ generally eat on the run ❒ eat constantly whether hungry or not
What are your symptoms if you miss a meal? ❒ Headache ❒ Irritable ❒ Light-headed ❒ Shaky ❒ Tired

Food frequency, number of servings per day:
Fruits (citrus, melons, etc.) _____ Dark green or deep yellow/orange vegetables _____ Grains (unprocessed)
_____ Beans, peas, legumes _____ Dairy, eggs _____ Meat, poultry, fish _____

(continued)

REVIEW OF SYSTEMS/HEALTH SCREENING HISTORY

Check the response that applies:

Y = current condition P = past condition N = a condition you've never had

GENERAL		When	
Weight		Height	
Weight 1 yr ago		Energy Level (1-10)	
Max Weight		General Daily Pain (1-10)	

SKIN	Y	P	N
Rashes			
Eczema,Hives			
Acne, Boils			
Itching			
Color Change			
Lumps			
Night Sweats			
Nails breaking			
Warts			
Fungal Infections			

HEAD	Y	P	N
Headache			
Head Injury			
Head Injury Date			
Migraines			
Hair Loss			

EYES	Y	P	N
Impaired Vision			
Glasses/Contacts			
Eye Pain			
Tearing/Dryness			
Double Vision			
Glaucoma			
Cataracts			
Light Sensitivity			
Dark Circles			
Puffy Eyes			

EARS	Y	P	N
Impaired Hearing			
Ringing			
Earache			
Dizziness			

NOSE/SINUSES	Y	P	N
Frequent Colds			
Frequent Infections			
Nose Bleeds			
Stuffiness			
Hay Fever			
Sinus Problems			

BLOOD	Y	P	N
Anemia			
Bleeding or Bruising			

MOUTH/THROAT	Y	P	N
Frequent Sore Throat			
Sore Tongue			
Gum Problems			
Hoarseness			
Dental Cavities			
Teeth Grinding			
Teeth Clenching			

NECK	Y	P	N
Lumps			
Swollen Glands			
Goiter			
Pain or Stiffness			

RESPIRATORY	Y	P	N
Cough			
Sputum			
Spitting up Blood			
Wheezing			
Asthma			
Bronchitis			
Pneumonia			
Pleurlsy			
Emphysema			
Difficulty Breathing			
Pain on Breathing			
Shortness of Breath			
At Night			
Lying Down			
Tuberculosis			

IMMUNE SYSTEM	Y	P	N
HISTORY OF:			
Epstein Barr			
Mono			
Herpes			
Shingles			
Hepatitis			
CMV			
Lupus			
Chron's			
Times sick in past year:			

CARDIOVASCULAR	Y	P	N
Heart Disease			
Angina			
High Blood Pressure			
Murmurs			
Rheumatic Fever			
Chest Pain			
Swelling in Ankles			
Palpitations, Fluttering			

GASTROINTESTINAL	Y	P	N
Trouble Swallowing			
Heartburn			
Change in Thirst			
Change in Appetite			
Easy fullness			
Nausea			
Vomiting			
Vomiting Blood			
Bowel Movements			
How Often?			
Is This a Change?			
Diarrhea			
Constipation			
Blood in Stool			
Belching or Gas			
Bloating			
Stomach Pain			
Jaundice (yellow skin)			
Liver Disease			
Hemorrhoids			
Gallbladder Attacks			

URINARY	Y	P	N
Pain with Urination			
Increased Frequency			
Frequency at Night			
Inability to Hold Urine			
Frequent Infections			
Kidney Stones			
Change in Urine Color			
Change in Urine Smell			

MUSCULOSKELETAL	Y	P	N
Joint Pain or Stiffness			
Arthritis			
Broken Bones			
Muscle Spasms or Cramps			
Weakness			
Chronic Fatigue			
Restless Legs			
Chronic Low Back Pain			
Motor Vehicle Accident			

PERIPHERAL VASCULAR	Y	P	N
Deep Leg Pain			
Cold Hands/Feet			
Varicose Veins			
Thombophlebitis			

NEUROLOGIC	Y	P	N
Fainting			
Seizures			
Paralysis			
Muscle Weakness			
Numbness or Tingling			
Loss of Memory			
Tremor			

EMOTIONAL	Y	P	N
Depression			
Mood Swings			
Anxiety or Nervousness			
Tension			
Trauma History			

BEHAVIORAL	Y	P	N
Bulimia			
Anorexia			
Addiction			
To What?			
Had Counseling			
Was it Effective?			

ENDOCRINE	Y	P	N
Hypothyroid			
Heat or Cold Intolerance			
Difficulty Losing Weight			
Difficulty Gaining Weight			
Excessive Thirst			
Excessive Hunger			
Binge Eating			
Change in Libido			

(continued)

FEMALE REPRODUCTIVE	Y	P	N
Age Menses Began			
Average Number of Days			
Length of Cycle			
Bleeding Between Periods			
Regular Cycles			
Extended Time Without Menses			
How Long?			
Pain During Intercourse			
Vaginal Dryness			
Vaginal Itchiness			
Yeast Infections			
Painful Menses			
Endometriosis			
PCOS			
Excessive Flow			
Excessive Facial Hair			
Excessive Body Hair			
Birth Control			
What Type?			
Number of Pregnancies			
Number of Live Births			
Number of Miscarriages			
Number of Abortions			
Difficulty Conceiving			

Menopausal Symptoms			
Describe:			
Age They Began			
Age of Your Mother at Menopause			
Are You Sexually Active?			
Sexual Difficulties			
Sexually Transmitted Infections			
If Yes, List:			
Sexual Preference			
Heterosexual			
Bisexual			
Lesbian			
Do You Perform Self Exam			
Breast Lumps			
Breast Pain or Tenderness			
Nipple Discharge			

MALE REPRODUCTIVE			
Hernias			
Testicular Masses			
Testicular Pain			
Are You Sexually Active			
Sexual Difficulties			
Prostate Problems			
Discharge or Sores			
Sexually Transmitted Infections			
If Yes, List:			
Sexual Preference			
Heterosexual			
Bisexual			
Gay			

IF NOT NOTED ABOVE IT IS NEGATIVE, NON-CONTRIBUTORY, AND/OR NON-PERTINENT.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Printed Name _____ Date _____

Signature_____ Relationship to Patient: _____