# 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 _____

Symptoms during allergy attack? _____

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

History of long-term antibiotic use? ❒ Y ❒ N How long? _____

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) |
|---|---|---|
| Primary Care Practitioner | | |
| OB/GYN | | |
| Dentist | | |
| Eye Care | | |
| Other | | |

IMMUNIZATIONS

Check those received: ❒ MMR ❒ DTaP ❒ Hep A ❒ HepB ❒ Hepatitis A / B ❒ Rotavirus ❒ Hib (Haemophilus) ❒ Polio ❒ Pneumococcal ❒ Varicella (Chicken Pox) ❒ Meningococcal ❒ HPV ❒ Tetanus ❒ Flu Shot ❒ Shingles ❒ Other: _____

TB test in last year? ❒ Y ❒ N Ever tested positive for TB? ❒ Y ❒ N Ever tested for HIV? ❒ Y ❒ N

List childhood illnesses: _____

List prior illness, injury, hospitalization, surgery (and dates): _____

(continued)

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

PERSONAL/FAMILY HISTORY

| | SELF | MOTHER | FATHER | SIBLINGS | OTHER (*see below) |
|---|---|---|---|---|---|
| **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/Other Eye Disorder | | | | | |
| Genetic Disease | | | | | |
| Heart Disease/Vascular Disorder | | | | | |
| Hepatitis/Other Liver Disorder | | | | | |
| 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 (Paternal Grandmother), PGF (Paternal Grandfather), Aunt(s), Uncle(s)

(continued)

Do You Use or Have Any of these Devices? ❒ Brace (Neck, Back) ❒ Pacemaker ❒ IUD ❒ Artificial Limbs
❒ Artificial Heart Valve ❒ Blood Vessel Stent ❒ Joint Replacement ❒ Other Metal Implants: _____

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(s) ❒ Spouse/Partner
❒ Children (list sex/ages): _____
Major stresses in last 12 months: ❒ Money ❒ Job ❒ Marriage ❒ Home Life ❒ Children
❒ Other stressors _____
Rate your stress level 1 to 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
❒ Other:_____
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: ❒ 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/Vertigo | | | |

| 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 | | | |
| Pleurisy | | | |
| 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 | | | |
| Times sick in past year: | | | |

| CARDIOVASCULAR | Y | P | N |
|---|---|---|---|
| Heart Disease | | | |
| Angina | | | |
| High Blood Pressure | | | |
| Murmurs | | | |
| Rheumatic Fever | | | |
| Chest Pain | | | |
| Swelling of 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? | | | |
| Inflammatory Bowel Disease | | | |
| Diverticulitis | | | |
| Diarrhea | | | |
| Constipation | | | |
| Blood in Stool | | | |
| Belching or Gas | | | |
| Bloating | | | |
| Stomach Pain | | | |
| Jaundice (yellow skin) | | | |
| Liver Disease | | | |
| Hemorrhoids | | | |
| Gallbladder Attacks/Stones | | | |
| Chron's | | | |

| 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 | | | |
| Thrombophlebitis | | | |

| 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/Hyperthyroid | | | |
| Heat or Cold Intolerance | | | |
| Difficulty Losing Weight | | | |
| Difficulty Gaining Weight | | | |
| Excessive Thirst | | | |
| Excessive Hunger | | | |
| Binge Eating | | | |
| Change in Libido | | | |

(continued)

Check the response that applies: Y = current condition P = past condition N = a condition you've never had

| 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 (Polycystic Ovary Syndrome) | | | |
| 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 | | | |
| Gay | | | |
| Lesbian | | | |
| Do You Perform Self Exam | | | |
| Breast Lumps | | | |
| Breast Pain or Tenderness | | | |
| Nipple Discharge | | | |

| MALE REPRODUCTIVE | Y | P | N |
|---|---|---|---|
| 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 | | | |

List additional health history which may be pertinent.

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

Printed Name _____ Date _____

Signature_____ Relationship to Patient: _____