



PATIENT HEALTH QUESTIONNAIRE

Name _____ Date _____ Birth date _____ Age _____

What other health care are you presently receiving? _____

PRESENT HEALTH CONCERNS

- 1. _____
2. _____
3. _____
4. _____

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? _____

Table with 3 columns: Current Medications, Dose, Times / Day. Below it, another table with 3 columns: Current Herbs / Vitamins/ Supplements, Dose, Times / Day.

PAST HEALTH HISTORY

Date of last physical exam _____ Where? _____

HEALTH SCREENING HISTORY: List the date of your most recent test or exam.

Mammogram _____ Pap Smear _____ Self Breast Exam _____ Breast Exam by Professional _____

Self Testicle Exam _____ Testicle Exam by Professional _____ Prostate Exam by Professional _____

Test for Blood in stool _____ Rectal Exam _____ Scope of Lower Bowel (if over age 50) _____

Blood tests: Cholesterol _____ Blood Sugar _____ Other Blood tests _____

Childhood illnesses: Your health as a child was [] Good [] Fair [] Poor

(please circle) Scarlet Fever German Measles Measles Pertussis Strep Mono Ear Infections
Diphtheria Mumps Chicken Pox Rheumatic Fever Polio Pneumonia

Immunizations (check those received): [] MMR [] DTaP [] HepB [] Rota [] Hib [] Polio [] Pneumococcal [] Varicella
[] Hep A [] Meningococcal [] HPV

Please list any adverse reactions: _____

Please List prior illness, injury, hospitalization, surgery, and/or trauma

Reason:

Date:

Recent immunizations: 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

PERSONAL AND FAMILY HISTORY

	Self	Mother	Father	Sisters	Brothers	Spouse	Child(ren)	Other
Age (if living)								
Age (at death)								
Cause of death								
Health; G = good, P = poor								
Check those applicable								
Alcoholism								
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								
Venereal Disease								
Other (specify)								

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)

REVIEW OF SYSTEMS

Circle the response that applies: Y = current condition

P = past condition

N = a condition you've never had

GENERAL

Weight _____ Weight 1 yr ago _____

Maximum weight _____

When _____ Height _____

Fatigue Y P N

Energy Level _____/10 high

Pain Level _____/10 high

SKIN

Rashes Y P N

Eczema, hives Y P N

Acne, boils Y P N

Itching Y P N

Color change Y P N

Lumps Y P N

Night sweats Y P N

Nails break easily Y P N

Warts Y P N

Fungal infections Y P N

HEAD

Headache Y P N

Head injury date _____ Y P N

Migraines Y P N

Hair loss Y P N

EYES

Impaired vision Y P N

Glasses or contacts Y P N

Eye Pain Y P N

Tearing or dryness Y P N

Double vision Y P N

Glaucoma Y P N

Cataracts Y P N

Sensitive to light Y P N

Dark circles under eyes Y P N

Puffy eyes Y P N

EARS

Impaired hearing Y P N

ringing Y P N

Earache Y P N

Dizziness Y P N

NOSE and SINUSES

Frequent colds Y P N

Frequent infections Y P N

Nose bleeds Y P N

Stiffness Y P N

Hay fever Y P N

Sinus problems Y P N

MOUTH and THROAT

Frequent sore throat Y P N

Sore tongue Y P N

Gum problems Y P N

Hoarseness Y P N

Dental cavities Y P N

Teeth grinding Y P N

Teeth clenching Y P N

NECK

Lumps Y P N

Swollen glands Y P N

Goiter Y P N

Pain or stiffness Y P N

RESPIRATORY

Cough Y P N

Sputum Y P N

Spitting up blood Y P N

Wheezing Y P N

Asthma Y P N

Bronchitis Y P N

Pneumonia Y P N

Pleurisy Y P N

Emphysema Y P N

Difficulty breathing Y P N

Pain on breathing Y P N

Shortness of breath Y P N

At night Y P N

Lying down Y P N

Tuberculosis Y P N

IMMUNE SYSTEM

History of:

Epstein Barr

Mono

Herpes

Shingles

Hepatitis

CMV

Lupus

Crohn's

How many times have you been sick in the past year? _____

CARDIOVASCULAR

Heart disease Y P N

Angina Y P N

High blood pressure Y P N

Murmurs Y P N

Rheumatic fever Y P N

Chest pain Y P N

Swelling in ankles Y P N

Palpitations, fluttering Y P N

GASTROINTESTINAL

Trouble swallowing Y P N

Heartburn Y P N

Change in thirst Y P N

Change in appetite Y P N

Easy Fullness Y P N

Nausea Y P N

Vomiting Y P N

Vomiting blood Y P N

Bowel movements

How often? _____

Is this a change? _____

Diarrhea Y P N

Constipation Y P N

Blood in stool Y P N

Belching or passing gas Y P N

Bloating Y P N

Stomach Pain Y P N

Jaundice (yellow skin) Y P N

Liver disease Y P N

Hemorrhoids Y P N

Gallbladder attacks Y P N

URINARY

Pain with urination Y P N

Increased frequency Y P N

Frequency at night Y P N

Inability to hold urine Y P N

Frequent infections Y P N

Kidney stones Y P N

Change in urine color Y P N

Change in urine smell Y P N

MUSCULOSKELETAL

Joint pain or stiffness Y P N

Arthritis Y P N

Broken bones Y P N

Muscle spasms or cramps Y P N

Weakness Y P N

Chronic fatigue Y P N

Restless legs Y P N

Chronic low back pain Y P N

Motor Vehicle Accident Y P N

PERIPHERAL VASCULAR

Deep leg pain Y P N

Cold hands/feet Y P N

Varicose veins Y P N

Thrombophlebitis Y P N

NEUROLOGIC

Fainting Y P N

Seizures Y P N

Paralysis Y P N

Muscle weakness Y P N

Numbness or tingling Y P N

Loss of memory Y P N

Tremor Y P N

EMOTIONAL

Depression Y P N

Mood swings Y P N

Anxiety or nervousness Y P N

Tension Y P N

Trauma History Y N

BEHAVIORAL

Bulimia Y P N

Anorexia Y P N

Addiction Y P N

To what? _____

Had counseling Y P N

Was it effective? Y N

ENDOCRINE

Hypothyroid Y P N

Heat or cold intolerance Y P N

Difficulty losing weight Y P N

Difficulty gaining wt. Y P N

Excessive thirst Y P N

Excessive hunger Y P N

Binge eating Y P N

Change in libido Y P N

BLOOD

Anemia Y P N

Easy bleeding or bruising Y P N

