PATIENT HEALTH QUESTIONNAIRE

NAME________________________________ DATE of BIRTH________________DATE___________

PLEASE TRY TO ANSWER ALL QUESTIONS ON BOTH SIDES. THIS INFORMATION WILL BE TREATED AS CONFIDENTIAL

PAST HEALTH

Have you ever suffered from any of the following conditions?

	Yes	No		Yes	No		Yes	No
Anemia			Heart Disease			Back Pain		
Thyroid Trouble			Tuberculosis			Emotional Problems		
Diabetes			Pneumonia			Epileptic Seizures		
Rheumatic Fever			Stomach Ulcers			Allergies		
High Blood Pressure			Kidney Disease (infections)			Jaundice		

Do you take any medications regularly? Yes No If yes, please list:________________________________

____

Alcohol use? Yes No Amount:___________________________

Illicit Drug use? Yes No Type:______________________________

Please list any significant illnesses or operations you have had.

Date	Illness or Operation	Doctor and/or Hospital
___________________	____	____________________________
___________________	____	____________________________
___________________	____	____________________________
___________________	____	____________________________
___________________	____	____________________________

FAMILY HEALTH

	Age	Health Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brothers and Sisters				
Children				

Has any Blood Relative Had	Y	N
Tuberculosis		
Heart Disease		
High Blood Pressure		
Alcoholism		
Kidney Disease		
Diabetes		
Strokes		
Epilepsy		
Mental Illness		
Allergies		
Lung Disease		

PATIENT HEALTH QUESTIONNAIRE

Are you affected by any of the following?

	Yes	No		Yes	No		Yes	No
Fatigue			Night Sweats			Difficulty Sleeping		
Loss of Appetite			Intolerance to Heat			Bleeding Tendency		
Loss of Weight			Intolerance to Cold			Date of Last Tetanus Shot		
Fever			Any Skin Trouble			Date of Late Polo Shot		
Chills			Fainting					

HEAD & NECK

	Yes	No		Yes	No		Yes	No
Headaches			Nasal Congestion			Frequent Colds		
Eye Trouble			Nose Bleeds			Sore Throat		
Hearing Difficulty			Hay Fever			Lumps in Neck		
Earaches			Dental Trouble			Neck Pain		
Sinus Trouble			Sore Tongue					

RESPIRATORY

	Yes	No		Yes	No		Yes	No
Cough			Wheezing			Cigarette Smoking Number Daily?		
Sputum			Shortness of Breath					
Bloody Sputum			Date of last TB test			Date of last Chest X-Ray		

CARDIOVASCULAR

	Yes	No		Yes	No		Yes	No
Shortness of Breath			Swelling of Ankles			Have you ever has an EKG (Electrocardiogram)? When?		
Chest Pain			Pains in Legs					
Palpitations			Varicose Veins			High Blood Pressure		

DIGESTIVE

	Yes	No		Yes	No		Yes	No
Difficulty Swallowing			Abdominal Pain			Bloody Stools		
Heartburn			Gas			Black Stools		
Nausea			Constipation			Do you take Laxatives?		
Vomiting			Diarrhea			Do any foods cause indigestion?		

URINARY

	Yes	No		Yes	No		Yes	No
Frequency of Urination			Change of Urine Appearance			Getting up at night to urinate? How Many Times?		
Painful Urination			Incontinence					

LOCOMOTOR

	Yes	No		Yes	No		Yes	No
Pain, stiffness, joint swelling			Any broken bones?			Back Pain		
Limitation joint movement			Foot Trouble			Deformities		

NERVOUS SYSTEM

	Yes	No		Yes	No		Yes	No
Forgetfulness			Abnormal Sensations			Difficulty Walking		
Nervousness			Loss of Balance			Tremors		
Depression			Clumsiness			Dizziness		
Spells of Any Kind			Muscle Weakness					

WOMEN ONLY

	Yes	No		Yes	No		
Irregular Menstruation			Are You Passed Menopause			Number Of Pregnancies	
Painful Menstruation			Abnormal Discharge			Number Of Miscarriages	
Very Heavy Periods			Do you take Birth Control Pills			Date of last Menstrual Period	
Bleeding between Periods			Any trouble with Breasts			Date of Last Pap Smear	