PATIENT HEALTH QUESTIONNAIRE

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PLEASE PRINT

Patient's Name: ______________________________ Acct #: ____________
(Office use Only)

HAVE YOU HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?
(Please circle answers)

Back Problems	Yes	No
Blood Disorders	Yes	No
Cancer	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Endocrine/Hormonal	Yes	No
Environmental Allergies	Yes	No
Gastrointestinal (Reflux/Ulcers)	Yes	No
HIV	Yes	No
Hearing Loss	Yes	No
Heart Disease	Yes	No
Hepatitis*	Yes	No
* If Yes – which type?	A B	C
High Blood Pressure	Yes	No
Infectious Disease	Yes	No
Kidney Disease	Yes	No
Language/Articulation	Yes	No
Pulmonary Problems	Yes	No
Seizure Disorders	Yes	No
Sinusitis	Yes	No
Stroke	Yes	No
Thyroid Disease	Yes	No
Vertigo/Dizziness	Yes	No

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS LISTED BELOW?
(Please circle answers)

NEUROLOGICAL:
- Headaches
- Weakness
- Numbness
- Fainting

CARDIOVASCULAR:
- Chest Pain
- Abnormal Heart Beat

MUSCULAR/SKELETAL:
- Muscle Aches
- Joint Aches

RESPIRATORY:
- Shortness of Breath
- Cough

PSYCHOLOGICAL:
- Depression
- Anxiety

DERMATOLOGIC:
- Rash
- Itchy Skin

Are you currently pregnant?
Yes No

GENERAL:
- Fatigue
- Weight Loss
- Weight Gain
- Fever/Chills

GASTROINTESTINAL:
- Constipation
- Diarrhea
- Heartburn
- Abdominal Pain

URINARY:
- Difficulty Urinating
- Frequent Urination

ENT:
- Blurry Vision
- Itchy Eyes
- Sneezing
- Bleeding Nose
- Noise in Ears
- Dizziness
- Hearing Loss
- Earaches
- Difficulty Swallowing
- Hoarseness
- Sore Throat
- Sinusitis
- Tonsil Issues

Please explain any problems you answered **YES:** ______________________________

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Please explain any other medical problems not listed above: ______________________________

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ALLERGIES:

Are you allergic to any medications? Yes No

Medications you are allergic to: ______________________________

Allergy to Nickel (i.e. cheap jewelry, eyeglasses)? Yes No

Allergy to Latex? Yes No If **Yes**, reaction: ______________________________

PLEASE COMPLETE OTHER SIDE →

Do you take any medications? **Please include prescription, over-the-counter, drops, sprays, vitamins and herbal supplements.**

MEDICATION NAME	DOSAGE (i.e. mg, mcg, etc.)	HOW OFTEN?

List **ANY AND ALL SURGICAL** Procedures you have had in your lifetime below:

TYPE OF SURGERY	DATE/YEAR

Current Occupation: ______________________ Currently Working? Yes No

Marital Status: Single Married Widowed Divorced Separated

Do you drink alcohol? Yes No How many drinks per week? ______________________

Do you currently use tobacco products? Yes No

Have you used tobacco in the past? Yes No

What type of tobacco? Cigarette Cigar Pipe Smokeless Tobacco

Amount of tobacco used daily? ______________ From ______________ (date) to ______________ (date)

Do you currently use illicit drugs? Yes No

Have you used illicit drugs in the past? Yes No

Type of drug(s) used? ______________ From ______________ (date) to ______________ (date)

FAMILY HISTORY

Please circle if anyone in your family has had any of the following (please indicate relationship to you)

Bleeding Disorder	Yes	No	Mother	Father	Brother	Sister
Cancer-type ____________	Yes	No	Mother	Father	Brother	Sister
Diabetes/Hypoglycemia	Yes	No	Mother	Father	Brother	Sister
Hearing Loss	Yes	No	Mother	Father	Brother	Sister
Cardiac/Heart Disease	Yes	No	Mother	Father	Brother	Sister
High Blood Pressure	Yes	No	Mother	Father	Brother	Sister
Stroke	Yes	No	Mother	Father	Brother	Sister
Thyroid Disease	Yes	No	Mother	Father	Brother	Sister

Other: ____