



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)

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS LISTED BELOW? (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 |
| Hearing Loss | Yes | No |
| Heart Disease | Yes | No |
| High Blood Pressure | Yes | No |
| Kidney Disease | Yes | No |
| Language/Articulation | Yes | No |
| Pulmonary Problems | Yes | No |
| Seizure Disorders | Yes | No |
| Sinusitis | Yes | No |
| Sleep Apnea | Yes | No |
| Stroke | Yes | No |
| Thyroid Disease | Yes | No |
| Vertigo/Dizziness | Yes | No |
| HIV | Yes | No |
| Hepatitis* | Yes | No |
| * If Yes – which type? | A B C | |
| Infectious Disease | Yes | No |

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

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
- Snoring

Are you currently pregnant?

Yes No

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

Please explain any other medical problems not listed above: _____

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

If retired, what industry did you work in? _____

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: _____

SKIN CANCER SCREENING

Have you had blistering sunburns as a child? Yes No

Please choose the **one** option that best describes your exposure to sun:

- Always burn on minimal sun exposure
- Burn very readily
- May burn on regular skin exposure with no protection
- Burns rarely
- Despite pigmentation, may burn surprisingly easily on sun exposure
- Rarely burns, although sunburn is difficult to detect on very pigmented skin