Patient Health Questionnaire

Patient Name:	
Today's Date: / /	Date of Birth: / /
Reason for Today's Visit:	

Social History

Marital Status	Single	Married	Divorced	Widowed
Alcohol Use	Yes ◯ No ◉	If yes, number of drinks per week:_____		
Tobacco Use	Yes ◯ No ◯	If yes, type and frequency:_____		
Exercise	Yes ◯ No ◯	If yes, type and frequency:_____		
Disability	Yes ◯ No ◯	If yes, type of disability:_____		

Past Medical History

Have you ever had or been diagnosed to have (*check all that apply*):

☐ Allergies	☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Bleeding Disorder	☐ Bone Disorder	☐ Cancer	☐ Cataracts	☐ Depression
☐ Diabetes	☐ Digestive Disorder	☐ Glaucoma	☐ Heart Attack	☐ Heart Disease
☐ Heart Murmur	☐ Hemorrhoids	☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease
☐ Kidney Stones	☐ Liver Disease	☐ Measles	☐ Pneumonia	☐ Prostate Disorder
☐ Seizure/Epilepsy	☐ STD	☐ Stroke	☐ TB/Lung Disease	☐ Thyroid Disease
☐ Ulcer	☐ Alzheimer's			

Medications & Dosage

List all prescription and OTC medications (*including dosage*) that you are currently taking:

Allergies

Do you have any known allergies? If so, please list/describe:

Past Surgical History

Please list any surgical procedures you have undergone:

Year	Surgery/Procedure

Family Medical History

	Age	Health	Age at Death	If deceased, cause	Comments
Father					
Mother					
Siblings					

Has any blood relative ever been diagnosed with any of the following conditions?

☐ Alzheimer's	☐ Heart Attack	☐ Alcoholism	☐ Tuberculosis	☐ Bleeding Disease
☐ Mental Disorder	☐ Diabetes	☐ Stroke	☐ Heart Disease	☐ Cancer

Reproductive History (Females Only)

Number of Children:	Last Menstrual Period:
Hysterectomy? Yes / No If yes, when:	Birth Control:

Review of Systems

Please indicate those items that you are currently experiencing or have recently experienced:

☐ Weight Change	☐ Vision Change	☐ Blurred Vision	☐ Hearing Aides	☐ Hearing Loss
☐ Sinus Problem	☐ Nose Bleed	☐ Chest Pain	☐ Heart Palpitations	☐ Shortness of Breath
☐ Cough	☐ Asthma	☐ Loss of Appetite	☐ Nausea	☐ Vomiting
☐ Fever	☐ Diarrhea	☐ Constipation	☐ Frequent Urination	☐ Pain w/ Urination
☐ Incontinence	☐ Joint Pain	☐ Weakness of muscle	☐ Back pain	☐ Change in skin color or moles
☐ Rash	☐ Breast Lump	☐ Headaches	☐ Numbness	☐ Tremors

Is there anything else you feel the doctor should know about you and/or your medical history?