

Today's Date / /

Instructions: Please answer all of the questions listed on this form. If you are currently experiencing any of the symptoms listed, or have experienced any of these symptoms in the last six (6) months, please check (X) the "YES" box next to the symptom, and provide any additional information in the space provided. For all other signs and symptoms listed, please check (X) the "NO" box next to the symptom. If you need assistance completing this form, please ask. Please be sure to sign and date this form on the reverse side. When you have completed and signed this form, please give the form to your provider. Thank you very much.

- YES NO
Does patient have an Advance Directive?
Does patient have a Living Will?

LAST EXAMS/LAB TESTS (Month/Year)

Cholesterol:
Colonoscopy:
Dental:
Eyes:
Mammogram:
Pap Smear:
Pelvic:
Prostate:
PSA Test:
Stool Tested:

- YES NO ALLERGY
Allergies/Allergic Reactions
If "YES," please list below:

- YES NO CONSTITUTIONAL
Fatigue (sluggish, tired)
Hyperactive (nervous energy)
Restless (can't relax/sit still)
Sleepiness During Day
Sleeplessness at night (insomnia)

- YES NO EMOTIONAL/MENTAL
Depression (feelings of hopelessness)
Anxiety (vague fears, uneasiness)
Mood swings (rapid distinct changes)
Irritability
Forgetfulness
Lack of concentration/focus

- YES NO HEAD/EARS
Headache (any kind)
Earache
Pain near ears
Ear infection

- YES NO HEAD/EARS, continued
Ringing in ear
Itchy Ears
Discharge from Ears

- YES NO SKIN
Blemishes, Acne
Rashes, Hives
Eczema
"Rosy" Cheeks
Moles
Skin sores/lumps
Unexplained Bruises

- YES NO NASAL/SINUS
Post Nasal Drip
Sinus Pain
Runny Nose
Stuffy Nose
Sneezing
Bloody Nose/Nosebleeds

- YES NO MOUTH/THROAT
Sore Throat
Swollen Throat
Swelling of Lips/Tongue
Gagging/Throat Clearing
Lesions ("Canker Sores")
Tooth/Teeth Pain
Bleeding Gums
Grinding Teeth at Night
Face/Jaw Injury

- YES NO LUNGS
Wheezing (Asthma or Asthma-like)
Chest Congestion
Non-Productive Coughing (no phlegm)
Productive Coughing (with phlegm)
Shortness of Breath
Bloody Cough

- YES NO EYES
Red or Swollen Eyes
Watery Eyes
Itchy Eyes

- YES NO EYES, continued
Dark Circles or "Baggy" Eyes
Blurred or Double Vision
Floaters or Spots in Vision

- YES NO GENITOURINARY
Increased Urinary Frequency
Painful Urination
Blood in Urine
Other Urinary Discharge
Male Patients Only
Enlarged Prostate
Impotence
Female Patients Only
Are you pregnant?
Last Menstrual Period (mm/dd/yyyy)
Irregular Periods
Urinary Tract Infections
Vaginal Discharge
Pain with Intercourse

- YES NO MUSCULOSKELETAL
Joint Pains/Aching
Stiff Joints
Muscle Aches
Stiff Muscles
Arthritis (Diagnosed)
Numbness (loss of sensation)

- YES NO CARDIOVASCULAR
High Blood Pressure
Rapid Heartbeat
Irregular Heartbeat
Chest Pain
Elevated Cholesterol

- YES NO GASTROINTESTINAL
Constipation
Diarrhea
Intestinal Pains/Cramps
Stomach Pains/Cramps
Vomiting
Bloody Vomiting
Painful Elimination

Patient's Name
Patient's Date of Birth
Patient's Gender

Street Address, Suite Number

Logo

City, State, Zip+4

PATIENT HEALTH QUESTIONNAIRE

#####

Today's Date / /

Patient Health Questionnaire, Page 2 of 2

- YES NO GASTROINTESTINAL, continued**
- Nausea
 - Gas
 - Bloating (Fullness) Sensation
 - Heartburn/Esoophageal Reflux
 - Bleeding with Bowel Movement
 - Liver Disease

- YES NO WEIGHT MANAGEMENT**
- Unexpected Weight Gain/Loss
 - Food Cravings
 - Binge Eating or Drinking
 - Increased Hunger
 - Increased Thirst
 - Loss of Appetite
 - Fluid Retention
 - Purging (all methods)

PATIENT SOCIAL HISTORY

Marital Status
 Divorced Domestic Partnered
 Married Single Widow(er)ed
 (CIRCLE ONE)

Occupation _____

- YES NO**
- Smoke cigarettes?
 _____ packs per day for _____ years

- YES NO PATIENT SOCIAL HISTORY**
- Smoke cigars?
 _____ per day for _____ years
 - Smoke pipes?
 - _____ bowls per day for _____ years
 - Drink alcohol?
 _____ drinks per day week month
 (CIRCLE ONE)
 - Recreational drug use? If yes, what kind?

- Sexually active?
- Change in sex drive?
- Sexual performance satisfactory?
- History of sexual trauma?
- Condom use
 Always Sometimes Rarely
 (CIRCLE ONE)
- Other contraceptive use? If yes, what kind? _____

YES NO PERSONAL HISTORY

- Heart Disease (heart attack, heart failure)
- Stroke
- High Blood Pressure
- Diabetes
- Cancer

YES NO FAMILY HISTORY (If "YES," note family member below)

- Heart Disease (heart attack, heart failure)
- Stroke _____
- High Blood Pressure _____
- Diabetes _____
- Cancer _____
- Glaucoma _____
- Vision Loss _____

YES NO ACCIDENT OR INJURY?

Describe physical injury:

 Activities worsening pain:

 Activities relieving pain:

MEDICATIONS (include prescription, over-the-counter, vitamins, herbals-include oral, eye, ear, and nose drops, suppositories, skin lotions and creams used on a regular basis.)			DOSAGE PER DAY	DATE STARTED	HOSPITALIZATIONS SURGERIES	DATE
1						
2						
3						
4						
5						

PROVIDER COMMENTS (Provider **MUST** review any "YES" responses and recommend appropriate follow up.)

"I have completed this form honestly and completely to the best of my knowledge and recollection."

PATIENT'S or AUTHORIZED REPRESENTATIVE'S SIGNATURE (Circle One) PRINT NAME DATE TIME

 AM
 PM

"I have reviewed this form with the patient and/or authorized representative."

PROVIDER'S SIGNATURE (include credentials, i.e., M.D., D.O.) PRINT NAME DATE TIME

 AM
 PM

Patient's Name _____ Patient's Date of Birth _____ Patient's Gender _____	Street Address, Suite Number <h2 style="text-align: center;">Logo</h2> City, State, Zip+4	PATIENT HEALTH QUESTIONNAIRE <h2 style="text-align: center;">*#####*</h2> Page 2 of 2 Form # Revised Form 08/2007
---	---	---