



PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____

PATIENT BIRTHDATE: _____

DATE TODAY: _____

HEALTH PROBLEMS	YES	NO	PLEASE EXPLAIN YES ANSWERS
AIDS OR POSITIVE HIV TEST(HOW LONG)			
ALCOHOL OR DRUG ABUSE			
ALLERGIES (ENVIROMENTAL)			
ANEMIA OR BLEEDING PROBLEMS			
ASTHMA OR EMPHYSEMA			
ARTHRITIS (STATE LOCATION)			
BACK OR NECK PROBLEMS			
BROKEN BONES(FRACTURES)			
CANCER (TYPE & YEAR DIAGNOSED)			
COUGH (CHRONIC) OR TUBERCULOSIS			
COLON PROBLEMS			
DEPRESSION OR ANXIETY			
DIABETES			
EAR DISEASE OR DEAFNESS			
ESOPHAGITIS (GERD)			
EYE DISEASE OR BLINDNESS			
GALLBLADDER DISEASE OR STONES			
GASTRITIS OR ULCERS			
HEART DISEASE			
HEART ATTACK			
HIGH BLOOD PRESSURE			
HIGH CHOLESTOROL			
KIDNEY DISEASE OR STONES			
LIVER DISEASE			
MIGRAINES OR OTHER HEADACHES			
SEIZURES			
SINUS PROBLEMS			
SMOKING(HOW MANY YEARS)			
THYROID DISEASE			
VENEREAL DISEASE			
OTHER HEALTH PROBLEMS			

LIST YOUR DAILY MEDICINES: NONE _____

ALLERGIES TO MEDICATIONS: NONE _____

CIRCLE YOUR OPERATIONS: NONE APPENDIX BACK NECK GALLBLADDER HERNIA HEART

HYSTERECTOMY C-SECTION TONSILS SINUS **OTHER OPERATIONS:** _____

HEALTH PROBLEMS THAT RUN IN YOUR FAMILY: _____

HOW LONG AGO WAS YOUR LAST TETANUS BOOSTER? _____

