

PATIENT HEALTH QUESTIONNAIRE

Name _____

Date _____

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, check that symptom in the Present column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

| Past | Present | Condition | Past | Present | Condition |
|--------------------------|--------------------------|-------------------------------------|---|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain Loss | <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia | <input type="checkbox"/> | <input type="checkbox"/> | Muscular In-coordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Ankle or Foot |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Lower Leg or Knee |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Leg or Hip |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast Soreness Lumps | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Profuse Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits | <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Stroke (Date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness of Joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash | <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Tumor, Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis | <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | Have You or Your Family Had: | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | Yes | No | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain (R _____ L _____) | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache _____ | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Back Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack (date) | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Lung Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Menstrual Flow | <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders (by condition) | Do you have a permanent disability rating? Yes ___ No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | Location _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gallbladder problems | Date rating received ? Rating Percentage _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite | | | |

Present Weight _____ **Pounds** **Height** _____ **Feet** _____ **Inches**

Please check any of the following that apply to you

| Past | Present | Condition | Past | Present | Condition |
|--------------------------|--------------------------|--|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy # births _____ | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco ___ packs/day |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth control pills, Type _____ | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol ___ drinks/day/week/month |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication (list if not listed elsewhere) | <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence |
| | | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Coffee/Tea/Caffeinated Soft drinks |
| | | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ cups/cans per day |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations/Surgical Procedures (List if not described elsewhere) | | | |

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition

Signature

Date