Name_____ **Date**_____

Patient Health Questionnaire

Allergies:

Please list any allergies: i.e. drug, environmental, food, allergies, etc.

_____
_____

Current Medications:

Please list any current medications: i.e. prescription drugs, OTC drugs, Supplements/Chinese herbal, etc.

_____
_____
_____

Illnesses and Surgeries:

Please list any previous or current illnesses: i.e. High blood pressure, diabetes, etc.

_____
_____
_____

Please list any previous surgeries, colonoscopies, ultrasounds, x-rays, CT scans, boned density, etc.:

_____
_____
_____

Social History

What is your marital status: Single/Married/Divorced/Widowed
# of Children: _____ School/Occupation: _____

What is your occupation? _____

Do you smoke? Yes/No - If yes, number of years?_____ Packs per day?_____

Do you drink Coffee/Tea/Soda? Yes/No - If yes, type? _____Amount of drinks per day/week? _____

Do you drink? Yes/No - If yes, how much do you drink? _____

Do you use recreational drugs? Yes/No - If yes, what type? _____

Immunization History

Vaccine	Year

Name _____ **Date** _____

Family Medical History:

Please list any Medical Conditions for your Family Members

Relationship	Medical Condition	Relationship	Medical Condition

*Uncle and Aunts when relevant to medical history.

Please list the current status of your Family Members

Mother	Alive: Yes/No	If No, Age at time of death: Cause of Death:
Father	Alive: Yes/No	If No, Age at time of death: Cause of Death:
Siblings	Alive: Yes/No	If No, Age at time of death: Cause of Death:
Brother/Sister	Alive: Yes/No	If No, Age at time of death: Cause of Death:
Brother/Sister	Alive: Yes/No	If No, Age at time of death: Cause of Death:
Brother/Sister	Alive: Yes/No	If No, Age at time of death: Cause of Death:
Brother/Sister	Alive: Yes/No	If No, Age at time of death: Cause of Death:
M. Grandmother	Alive: Yes/No	If No, Age at time of death: Cause of Death:
M. Grandfather	Alive: Yes/No	If No, Age at time of death: Cause of Death:
P. Grandmother	Alive: Yes/No	If No, Age at time of death: Cause of Death:
P. Grandfather	Alive: Yes/No	If No, Age at time of death: Cause of Death:

Note if any family members had genetic testing (BRCA or other cancer risk testing) _____

Review of Systems- Please check all that apply:

	EYES		**(Con't Gastro)**		**(Con't Neuro)**
	Blurred vision		Frequent heartburn		Dizziness
	Double vision		Frequent indigestion		Loss of consciousness/fainting
	Trouble seeing		Difficulty swallowing		Change in mental status
	Glaucoma		Loss of appetite		Memory loss
			Black tarry stool		Seizures
	ENMT				Speech problems
	Hearing loss		**GENITOURINARY**		Headaches
	Hearing changes		Frequency of urination		Migraines
	Ear pain		Blood in urine		Disorientation
	Ringing in the ears		Urgency		Loss of coordination
	Ear discharge		Difficulty urinating		Difficulty walking
	Nose bleeds		Painful urination		Weakness, numbness, tingling
	Sinus drainage		Incontinence		Tremors
	Mouth/cold sores		Kidney infection		
	Sore throat		Kidney stones		**PSYCHIATRIC**
	Hoarseness		Loss of libido		Depression
	Difficulty swallowing		Sexual difficulty		Anxiety
	Dental problems		Pain in intercourse		Panic attacks
	Bleeding gums		Excessive menstrual bleeding		Agitation
			Irregular periods		Apprehension
	CARDIOVASCULAR		Hot flashes		Hallucinations
	Chest pain		Vaginal discharge		Insomnia
	Shortness of breath		Nipple discharge		Anger/resentment
	Irregular heartbeat		Menstrual cramps		
	Heart murmurs		Premenstrual depression		**ENDOCRINE**
	Pain down left arm		Lumps in breast		Excessive thirst
	Heart palpitations		Burning in urination		Excessive urination
	Ankle swelling		Difficulty starting to urinate		Heat or cold intolerance
			Nightly urination		Excessive sweating
	RESPIRATORY		Dripping after urination		Hair loss
	Cough		Penile sores		
	Congestion				**HEMATOLOGIC/LYMPHATIC**
	Sputum production		**MUSCULOSKELETAL**		Excessive fatigue
	Shortness of breath		Joint pain		Excessive bruising
	Coughing up blood		Joint swelling		Blood in stool
	Wheezing		Back pain		Excessive bleeding
	Chest pain w/ breathing		Muscle spasms		Lymph node swelling
	Daytime sleepiness		Muscle weakness		
	Excessive snoring		Muscle pain		**ALLERGIC/IMMUNOLOGIC**
					Frequent sinus trouble
	GASTROINTESTINAL		**INTEGUMENTARY**		Catches colds easily
	Abdominal pain		Rash		Drug sensitivity
	Nausea		Itching		Environmental sensitivity
	Vomiting		Bruising		Hay fever
	Diarrhea		Hives		Food allergies/intolerances
	Constipation		Skin ulcers/sore		
	Gas and bloating		Slow healing		**CONSTITUTIONAL SYMPTOMS**
	Vomiting blood		Change in skin color		Weight loss/weight gain
	Rectal bleeding		Scars		Chills
	Abdominal distension				Fever
	Jaundice		**NEUROLOGICAL**		Fatigue
	Mucus in bowel movement		Light headedness		Night sweats