

Patient Health Questionnaire

Name: _____ DOB ____/____/____

Chief complaint (reason being seen): _____

Current Medications (both prescription and non-prescription): _____

Medical History: _____

Allergies: _____

Surgical and Hospital history: _____

Family History (circle appropriate):

Epilepsy	Thyroid	Osteoporosis	High Cholesterol
Migraine	Hay fever	Arthritis	Alcoholism
Mental Illness	Asthma	Heart Disease	Cancer
Glaucoma	Anemia	Stroke	Hypertension
Bleeds Easily	Diabetes	Other: _____	

Social History: Smoker = YES/NO, If yes, how long and how much per day? _____

(Circle Yes or No) Alcohol = YES/NO, If yes, how much per day/week? _____

Exercise = YES/NO, If yes, how often? _____

Special Diet = YES/NO, If yes, specify: _____

Vaccinations: _____