

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: _____