

# PATIENT HEALTH QUESTIONNAIRE

PATIENT'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

CHIEF COMPLAINT: \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

## MEDICAL HISTORY

Anemia	Y / N	Arthritis	Y / N
Radiation Treatment	Y / N	Heart Surgery	Y / N
Artificial Joints	Y / N	Pacemaker	Y / N
Asthma	Y / N	Hemophilia/Abnormal Bleeding	Y / N
Difficulty Breathing	Y / N	Hepatitis	Y / N
Blood Transfusion	Y / N	High/Low Blood Pressure	Y / N
Cancer/ Chemotherapy	Y / N	H.I.V/AIDS	Y / N
Congenital Heart Defect	Y / N	Kidney Problems	Y / N
Diabetes	Y / N	Mitral Valve Prolapse	Y / N
Emphysema	Y / N	Psychiatric Problems	Y / N
Epilepsy/Seizures	Y / N	Rheumatic/Scarlet Fever	Y / N
Heart Attack/Stroke	Y / N	Migraines	Y / N
Ulcers/Colitis	Y / N	Venereal Disease	Y / N
Blood Clot	Y / N	Thyroid Disease	Y / N
Other Medical Condition: _____			

## ALLERGIES

Aspirin Y / N  
Penicillin Y / N  
Codeine Y / N  
Latex Y / N  
Other: \_\_\_\_\_

## HABITS

Smoke/How Often? \_\_\_\_\_ Y / N  
Alcohol/ Amount? \_\_\_\_\_ Y / N  
Drug Abuse? \_\_\_\_\_ Y / N

## SURGICAL HISTORY

1. \_\_\_\_\_ DATE: \_\_\_\_\_  
2. \_\_\_\_\_ DATE: \_\_\_\_\_  
3. \_\_\_\_\_ DATE: \_\_\_\_\_  
4. \_\_\_\_\_ DATE: \_\_\_\_\_  
5. \_\_\_\_\_ DATE: \_\_\_\_\_  
6. \_\_\_\_\_ DATE: \_\_\_\_\_  
7. \_\_\_\_\_ DATE: \_\_\_\_\_  
8. \_\_\_\_\_ DATE: \_\_\_\_\_  
9. \_\_\_\_\_ DATE: \_\_\_\_\_

## CURRENT MEDICATIONS

*Please Specify what condition Medication is for:*

1. \_\_\_\_\_ FOR: \_\_\_\_\_  
2. \_\_\_\_\_ FOR: \_\_\_\_\_  
3. \_\_\_\_\_ FOR: \_\_\_\_\_  
4. \_\_\_\_\_ FOR: \_\_\_\_\_  
5. \_\_\_\_\_ FOR: \_\_\_\_\_  
6. \_\_\_\_\_ FOR: \_\_\_\_\_  
7. \_\_\_\_\_ FOR: \_\_\_\_\_  
8. \_\_\_\_\_ FOR: \_\_\_\_\_  
9. \_\_\_\_\_ FOR: \_\_\_\_\_