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Patient Health Questionnaire **Please Print**

General Health Information:

Main reason for visit: _____

Please list below any past medical history, hospitalizations or surgeries with the year it took place:

Do you smoke? _____ How much alcohol do you drink? _____

History Please mark an "X" for yourself, or an "R" for a blood relative

Neurological _____	Lung Disease Recent _____	Weight Loss _____
Epilepsy/Convulsions _____	Arthritis _____	Stomach Ulcers _____
Migraine Headache _____	Osteoporosis _____	Liver/Hepatitis _____
Mental Illness _____	Heart Valve Disorder _____	Kidney/Bladder _____
Depression _____	Heart Attack _____	Bowel Problems _____
Alcoholism _____	Angina/Chest Pain _____	
Drug Abuse _____	High Blood Pressure _____	Diabetes _____
	High Cholesterol _____	HIV _____
Eye Disease _____	Stroke _____	Blood Transfusions _____
Hearing Disorder _____		Bleeding Disorder _____
Nose Bleeds _____	Cancer _____	
Sinus Infections _____	Type _____	Anemia _____

Please check and date if/or when you last received any of the following procedures:

Flu Vaccine _____	Pneumonia Vaccine _____	Bone Density Scan _____
Hepatitis Vaccine _____	Cholesterol Test _____	Shingles Vaccine _____
Tetanus Vaccine _____	Colonoscopy/Sigmoidoscopy _____	PSA _____

Women's Health

Date of Last Period _____ Current Method Birth Control _____

Number of Pregnancies _____ Number of Births _____

Dates of Last:

Pap test: _____	Results: _____
Breast Exam: _____	Results: _____
Mammogram: _____	Results: _____
HPV vaccine: _____	

Patient Name: _____ Date: _____