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Patient Health Questionnaire:

We would like to get to know you. Please Print.

Primary reason for today's visit: _____

Medication Allergies: _____

Current Medications: Please list ALL medicines including over the counter and supplements

Name	Dose	Times taken Daily

Pharmacy Information:

Name: _____

Address: _____

Patient Name: _____ Date: _____

Review of Systems:

Please mark **YES** if you have any of the following.

	YES			YES
General			**Respiratory**	
Weight gain			Shortness of breath	
Weight loss			Cough	
Memory loss			Wheezing	
Fatigue			Sputum	
Fever/chills				
Night sweats			**Cardiac**	
Change in appetite			Chest pain	
			Palpitations	
Eyes			Murmur	
Glasses			Leg swelling	
Contact Lenses				
Blurriness			**Gastrointestinal**	
Tearing			Heartburn	
Itching			Nausea/Vomiting	
Vision Loss			Abdominal Pain	
			Diarrhea	
Head and Neck			Constipation	
Headache			Blood in stool	
Sore Throat				
Ear Pain			**Genitourinary**	
Nasal Discharge			Pain with urination	
Hearing loss			Hesitancy	
Ear Ringing			Blood in urine	
			Incontinence	
Skin				
Rash			**Neurologic**	
Eczema			Numbness/tingling	
			Weakness	
Musculoskeletal				
Joint pain			**Psychological**	
Joint swelling			Depressed	
Joint stiffness			Anxiety	

Patient Name: _____Date of Birth:_____

Please list past **medical** history including dates:

_____
_____
_____
_____

Please list past **surgical** history or **procedures** including dates:

_____
_____
_____
_____

Please list all pertinent family medical history including type of relative (e.g. Aunt)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Relationship status:

Married/Partner ◯ Single ◯ Divorced ◯ Widowed ◯

Are you currently sexually active?

Preferred sexual partner: Men ◯ Women ◯ Both ◯ Never sexually active ◯

Do you smoke? If so, how much and for how long: _____

Do you drink alcohol? If so, how much: _____

Vaccines: If received, please give date:

Tetanus/tdap_____ Influenza _____ Hepatitis A / B _____
Pneumonia _____ Shingles _____ Gardasil _____

Women's Health

Last Menstrual Cycle: _____ Are you on birth control /type? _____

Number of Pregnancies: _____ Number of births: _____
Pap Test:_____Breast Exam/Mammogram: _____

Please describe your diet and physical activity/exercise:

_____

Preventative Health

Please include dates:

Colonoscopy: _____ Bone Density Test: _____

Most recent set of lab work:_____

Patient Name:_____Date of Birth:_____