Patient Health Questionnaire

Patient Name: **DOB**: **Date:**

YES	NO	ALLERGY	YES	NO	NASAL/SINUS	YES	NO	MUSCULOSKELETAL
		If “YES”, please list			Post Nasal Drip			Joint Pains/Aching
					Sinus Pain			Stiff Joints
					Runny Nose			Muscle Aches
					Stuffy Nose			Arthritis
					Sneezing			Numbness
								Stiff muscles
								Tingling
			YES	**NO**	**MOUTH/THROAT**			
					Sore Throat	**YES**	**NO**	**CARDIOVASCULAR**
YES	**NO**	**CONSTITUTIONAL**			Swollen Throat			High Blood Pressure
		Fatigue (tired)			Swelling of lips/tongue			Rapid heart beat
		Hyperactive			Gagging			Irregular heartbeat
		Restless			Canker Sores			Chest Pain
		Daytime sleepiness			Difficulty swallowing			Elevated cholesterol
		Insomnia			Hoarseness			Calf pain on walking
		Snoring						
			YES	**NO**	**LUNGS**	**YES**	**NO**	**GASTROINTESTINAL**
					Asthma			
YES	**NO**	**EMOTIONAL/MENTAL**			Chest congestion			Constipation
		Depression			Coughing			Diarrhea
		Anxiety			Productive cough			Stomach pains/cramps
		Mood Swings			Shortness of breath			Vomiting
		Irritability						Painful elimination
		Forgetfulness	**YES**	**NO**	**EYES**			Nausea
		Lack of concentration			Red or Swollen eyes			Gas
					Watery eyes			Bloating/easily full
YES	**NO**	**HEAD/EARS**			Itchy eyes			Heartburn
		Headache			Dark circles/baggy			
		Earache			Blurred vision	**YES**	**NO**	**WEIGHT MANAGEMENT**
		Ear infection			Double vision			Weight gain
		Ringing in ear			Floaters or Spots			Weight loss
		Dizziness						Binge eating
		Discharge from ears	**YES**	**NO**	**GENITORUINARY**			Increased hunger
					Increased urination			Increased Thirst
YES	**NO**	**SKIN**			Painful urination			Loss of appetite
		Blemishes, Acne			Blood in urine			Fluid retention
		Rashes			**Male patients**			
		Darkening of the skin			Sexual difficulties			
		Hives			Enlarged prostate			
		Itching			Decreased libido			
		Eczema			**Female Patients**			
		Moles			Irregular periods			
		“Rosy” cheeks			Bladder infections			
		Skin sores/lumps			Yeast infections			
		Unexplained bruises						
		Light spots						

Patient Name:						**DOB**:		**Date:**
		Increased hair on body						
		Hair thinning/loss						
							CURRENT MEDICATIONS (including over the counter)	
Check one		**PATIENT SOCIAL HX**	**YES**	**NO**	**PERSONAL HX**			
		Marital Status			Heart Disease			
		Divorced			Stroke			
		Married			High blood pressure			
		Single			Diabetes			
		Domestic partnered			Cancer			
		Separated			Arthritis			
YES	**NO**	**Tobacco use?**			Thyroid			
		If yes			Kidney problems			
		What type?			Elevated cholesterol			
		How much?			Other			
		per day for years	**YES**	**NO**	**Family HX**		**HOSPITALIZATION/SURGERIES**	
		Last use of tobacco?			Heart Disease		**Date**	
					Stroke			
YES	**NO**	**Drink Alcohol?**			High blood pressure			
		drinks per day			Diabetes			
		drinks per week			Cancer			
		drinks per month			Arthritis			
		Last use?			Thyroid			
YES	**NO**	**Recreation drug use?**			Mental Illness			
		If yes, what kind?			Kidney problems			
		Last use?			Elevated cholesterol			
		Sexually active?			Glaucoma			
		Condom use			Other			
		Contraceptive use						
		If yes, what kind?						
Patient Comments								

Physician Comments

Date		**Physician Signature**