

PATIENT HEALTH QUESTIONNAIRE

NAME _____ DATE _____

DO YOU HAVE OR HAVE A HISTORY OF THE FOLLOWING:

	Y	N		Y	N		Y	N
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/black out(s)	<input type="checkbox"/>	<input type="checkbox"/>	Are you post menopausal?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Polio/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Back pain/injury	<input type="checkbox"/>	<input type="checkbox"/>	Would you agree to a blood transfusion in a life threatening case?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Numbness arms/legs	<input type="checkbox"/>	<input type="checkbox"/>	Do you use Retin A?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Do you now or have you ever in the past taken Accutane?	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beats	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell illness	<input type="checkbox"/>	<input type="checkbox"/>	Do you take Aspirin or Anticoagulants?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s)	<input type="checkbox"/>	<input type="checkbox"/>	Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	Do you take Plavix?	<input type="checkbox"/>	<input type="checkbox"/>
Seizure/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma/cataracts	<input type="checkbox"/>	<input type="checkbox"/>			
Easy bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____		
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores/fever blisters			_____		
Liver disease/hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes simplex	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/hiatal hernia			_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Esophageal reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Poor scarring/keloids	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Other lung issues	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>			
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Wear eyeglasses?	<input type="checkbox"/>	<input type="checkbox"/>			
Heart attack(s)	<input type="checkbox"/>	<input type="checkbox"/>	Wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Wear hearing aids?	<input type="checkbox"/>	<input type="checkbox"/>			
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>			

List all previous surgeries:

List any allergies to drugs or medications:

List all medications currently taking, including over-the-counter medications, herbs and vitamins:

COMMENTS:
