PATIENT HEALTH QUESTIONNAIRE

NAME _____ **DATE** _____

DO YOU HAVE OR HAVE A HISTORY OF THE FOLLOWING:

Heart Issues	**Y**	**N**
Fainting/blackout(s)	☐	☐
Irregular heartbeats	☐	☐
High blood pressure	☐	☐
Chest pain	☐	☐
Heart failure	☐	☐
Heart attack(s)	☐	☐
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Have you had an EKG?	☐	☐
Do you have a Cardiologist?	☐	☐
Do you take Aspirin or Anticoagulants?	☐	☐

Lung Issues	**Y**	**N**
Asthma/emphysema	☐	☐
Shortness of breath	☐	☐
Sleep apnea	☐	☐
Tuberculosis	☐	☐
Do you use inhalers?	☐	☐
Do you wear CPAP at night?	☐	☐

Neurological Issues	**Y**	**N**
Stroke(s)	☐	☐
Polio/paralysis	☐	☐
Numbness of arms/legs	☐	☐
Seizure/epilepsy	☐	☐

Digestive Issues	**Y**	**N**
Heartburn/ Esophageal reflux	☐	☐
Hiatal Hernia	☐	☐
Difficulty swallowing	☐	☐
Liver disease/hepatitis	☐	☐

Endocrine Issues	**Y**	**N**
Diabetes	☐	☐
Low blood sugar	☐	☐
Thyroid disease	☐	☐

Urological Issues	**Y**	**N**
Renal insufficiency	☐	☐
Kidney disease	☐	☐
Urinary retention	☐	☐
Urinary incontinence	☐	☐
Prostate issues, if applicable	☐	☐
Do you take any diuretics?	☐	☐

Blood Disorders/Cancers	**Y**	**N**
Sickle Cell Disease	☐	☐
HIV	☐	☐
Anemia	☐	☐
Cancer	☐	☐

Musculoskeletal Issues	**Y**	**N**
Back pain/injury	☐	☐
Neck pain/injury	☐	☐

Eyes/Ears/Mouth Issues	**Y**	**N**
Dry eyes	☐	☐
Glaucoma/cataracts	☐	☐
Wear eyeglasses?	☐	☐
Wear contact lenses?	☐	☐
Wear hearing aids?	☐	☐
Wear dentures?	☐	☐

Mental Health Issues	**Y**	**N**
Depression	☐	☐
Anxiety	☐	☐

OVER ----------→

Skin Issues	Y	N
Do you or have you ever taken Accutane?	☐	☐
Do you use Retin A?	☐	☐
Poor scarring/keloids	☐	☐
Cold sores/fever blisters/ Herpes simplex	☐	☐
Easy bleeding/bruising	☐	☐

Other	Y	N
Do you have a history of MRSA?	☐	☐
Are you postmenopausal?	☐	☐
Are you or could you be pregnant?	☐	☐
Alcohol use?	☐	☐
Do you smoke or vape?	☐	☐

Weight_____ Height_____ BMI_____

List all previous surgeries:

_____

_____

List any allergies to drugs/medications, and the reactions:

_____

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

_____

_____

COMMENTS/any other health conditions not mentioned above:

_____

_____