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PATIENT HEALTH QUESTIONNAIRE

Dear Patient,

In order to assess your healthcare needs and to better serve you, we ask that you answer all the questions below as accurately as possible:

TODAYS DATE:______________________________

NAME:____ DOB: _________________________________

FAMILY PHYSICIAN: _______________________________ PHARMACY: __________________________

What is the purpose of your visit today? ____

____

SYMPTOMS: Please check the YES/NO box with your response :

YES	NO	Symptom
☐	☐	**Frequency of Urination**
☐	☐	**Bladder Pain**
☐	☐	**Pain with Urination**
☐	☐	**Dribbling after Urination**
☐	☐	**Fever/Chills**
☐	☐	**Nausea/Vomiting**
☐	☐	**Previous Kidney Stones**
☐	☐	**Penis Pain or Discharge**
☐	☐	**Testicle pain or Swelling**
☐	☐	**Pain with Ejaculation**
☐	☐	**Urgency with Urination**
☐	☐	**Decreased force or pressure of stream**
☐	☐	**Abdominal Pain**
☐	☐	**Changes in bowel habits**
☐	☐	**Pain in the side**
☐	☐	**Incomplete Bladder Emptying**
☐	☐	**Blood in the Urine**
☐	☐	**Strain to Empty Bladder**
☐	☐	**# of times you get up at night to urinate____**
☐	☐	**Incontinence (leakage of urine)**
☐	☐	**Vaginal pain or Discharge**

How long have these problems been bothering you?_______________________________________

Have you been treated for a sexually transmitted disease? ☐ **YES** ☐ **NO**

Do you have sexual concerns? ☐ **YES** ☐ **NO**

Do you have any erectile problems? ☐ **YES** ☐ **NO**

Are any of the above symptoms getting worse? ☐ **YES** ☐ **NO**

How would you rate your general health: ☐ **Excellent** ☐**Very Good** ☐**Good** ☐ **Fair** ☐ **Poor**

PAST HEALTH PROBLEMS: Please check all that apply.

- ☐ **Arthritis**
- ☐ **Glaucoma/ Eye Problems**
- ☐ **Back Problems**
- ☐ **Emphysema**
- ☐ **Blood Clots**
- ☐ **Heart Problems**
- ☐ **Breathing Problems**
- ☐ **Hepatitis**
- ☐ **Cancer**
- ☐ **High Blood Pressure**
- ☐ **Cholesterol Problems**
- ☐ **Stomach Ulcers**
- ☐ **Depression**
- ☐ **Stroke**
- ☐ **Diabetes**

PLEASE LIST ALL OTHER PAST MEDICAL HEALTH PROBLEMS NOT LISTED ABOVE:

____

____

PREVIOUS SURGERY: (List approximate year of surgery)

Tonsils/Adenoids______________________
Appendectomy________________________
Joint Replacement_____________________
Breast_______________________________
Gallbladder _________________________
Prostate_____________________________
Bladder_____________________________
Hysterectomy___________________________
Hernia_________________________________
Cardiac Bypass_________________________
Cardiac Stent Placement________________
Vasectomy______________________________
Removal of Ovaries_________________

PLEASE LIST ALL OTHER SURGERIES YOU HAVE HAD THAT ARE NOT LISTED ABOVE:
____
____

HAVE YOU HAD ANY PRIOR PROBLEMS WITH ANESTHESIA? ☐ **YES** ☐ **NO**
IF YES, WHAT HAPPENDED? ____
____

PLEASE LIST ANY ALLERGIES YOU HAVE TO PRESCRIPTION MEDICATION:
____
____

FOOD ALLERGIES: ____

OTHER SUBSTANCES (tape, latex, etc):____

Can you eat strawberries, shellfish, or iodized salt? ☐ **YES** ☐ **NO**

Do you have any religious beliefs that would not allow you to receive a blood transfusion or any blood products if needed? ☐ **YES** ☐ **NO**

SOCIAL HISTORY:
Are you married? ☐ **YES** ☐ **NO** Widowed ☐ **YES** ☐ **NO** Divorced ☐ **YES** ☐ **NO**

Do you live with a significant other? ☐ **YES** ☐ **NO**

# of children _____________

What is your occupation? _______________________________Job description:____________________________

Have you *ever* smoked cigarettes or used tobacco in any form? ☐ **YES** ☐ **NO**

Do you currently? ☐ **YES** ☐ **NO** If so, how many packs a day?______ For how many years?___________

Do you drink alcoholic beverages? ☐ **YES** ☐ **NO** If so, how many per week? _______________________

FEMALES:
# of Pregnancies__________ # of live Births ____________ # of Miscarriages ___________

NAME:____DOB:_________________________________

FAMILY HISTORY: PLEASE LIST ANY FAMILY MEMBER WITH ANY OF THE DISORDERS LISTED BELOW:

Cancer/Tumor________________________________
HIV/AIDS________________________________
Anesthesia Problems________________________________
Bleeding Problems________________________________
High Blood Pressure________________________________
Kidney Cancer________________________________
Heart Problems________________________________
Diabetes________________________________
Kidney Stones________________________________
Prostate Cancer________________________________
Hepatitis________________________________
Asthma/Emphysema________________________________
Bladder Cancer________________________________
Tuberculosis________________________________
Strokes________________________________
Heart Attack________________________________
Thyroid Problem________________________________

REVIEW OF SYSTEMS:

PLEASE CHECK YES/NO ON ALL CURRENT PROBLEMS OR PAST HEALTH PROBLEMS:

YES NO

Constitutional Symptoms
- ☐ ☐ Fever
- ☐ ☐ Chills
- ☐ ☐ Weight Loss/Gain

Eyes
- ☐ ☐ Double Vision
- ☐ ☐ Pain
- ☐ ☐ Blurred Vision

Ear/Nose/Throat/Mouth
- ☐ ☐ Sinus Problems
- ☐ ☐ Sore Throat
- ☐ ☐ Ear Infection

Respiratory
- ☐ ☐ Shortness of breath
- ☐ ☐ Frequent cough
- ☐ ☐ Wheezing

Gastrointestinal
- ☐ ☐ Indigestion/Heartburn
- ☐ ☐ Nausea/Vomiting
- ☐ ☐ Abdominal Pain

Genitourinary
- ☐ ☐ Urinary Frequency
- ☐ ☐ Painful Urination
- ☐ ☐ Urine Retention

Musculoskeletal
- ☐ ☐ Back Pain
- ☐ ☐ Neck Pain
- ☐ ☐ Joint Pain

YES NO

Integumentary
- ☐ ☐ Boils
- ☐ ☐ Persistent Itching
- ☐ ☐ Skin Rash

Neurological
- ☐ ☐ Numbness/Tingling
- ☐ ☐ Dizzy spells
- ☐ ☐ Tremors

Endocrine
- ☐ ☐ Tired/Sluggish
- ☐ ☐ Too hot/cold
- ☐ ☐ Excessive thirst

Hematologic/Lymphatic
- ☐ ☐ Blood clotting problem
- ☐ ☐ Swollen glands

Allergic/Immunologic
- ☐ ☐ Drug allergies
- ☐ ☐ Hay fever
- ☐ ☐ Shellfish/Strawberries

Cardiovascular
- ☐ ☐ Chest pain
- ☐ ☐ Abnormal heart pain
- ☐ ☐ High blood pressure

Psychologic
- ☐ ☐ Are you generally satisfied with your life?
- ☐ ☐ Do you feel severely depressed?
- ☐ ☐ Have you ever considered suicide?

Please add anything below, which you feel, will help us with your medical care:

____

____

NAME:____________________________________DOB:____________________________________