Patient Health Questionnaire

Patient Name _____ *Date* _____

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height ___ *Feet* ___ *Inches* Weight ___ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Use Tobacco Products
						☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain				☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite			***Females Only***
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Birth Control Pills
			☐	☐	Ulcer	☐	☐	Hormonal Replacement
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	
☐	☐	Rheumatoid Arthritis						
			☐	☐	Cancer			***Other Health Problems/Issues***
☐	☐	General Fatigue	☐	☐	Tumor	☐	☐	
☐	☐	Muscular Incoordination				☐	☐	
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	
☐	☐	Dizziness	☐	☐	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____

_____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____

_____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

Doctors Signature _____ ***Date*** _____