PRIME HEALTHCARE PROVIDERS

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PATIENT HEALTH QUESTIONNAIRE

(Please complete both front and back of form)

GENERAL INFORMATION:

NAME: (first, MI, last) , ,		TODAY'S DATE: / /
AGE:	BIRTHDATE: / /	DATE LAST PHYSICAL EXAM: / /

WHAT IS THE REASON FOR TODAY'S VISIT ?

1.	3.
2.	4.

PAST HEALTH: *ONLY Check (✓) if it applies to you, those conditions you have now or have had in the past.*

☐ Aids	☐ Chicken Pox	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Diabetes	☐ HIV positive	☐ Psychiatric Care
☐ Anemia	☐ Emphysema	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia	☐ Epilepsy	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Glaucoma	☐ Measles	☐ Stroke
☐ Arthritis	☐ Gonorrhea	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Gout	☐ Miscarriages	☐ Thyroid Problem
☐ Bleeding disorder	☐ Heartburn	☐ Mononucleosis	☐ Tonsillitis
☐ Breast lump	☐ Heart Disease	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Hepatitis	☐ Mumps	☐ Typhoid Fever
☐ Cancer	☐ Hernia	☐ Pacemaker	☐ Ulcers
☐ Cataracts	☐ Herpes	☐ Pneumonia	☐ Vaginal Infections
☐ Chemical Dependency	☐ High Blood Pressure	☐ Polio	☐ Venereal Disease

MEDICATIONS: *List the medications & the doses that you are currently taking.* **ALLERGIES -- REACTION**

1.	5.	--
2	6.	--
3.	7.	--
4.	8.	--

IMMUNIZATIONS: *ONLY Check (✓) if it applies to you.*

☐ Hepatitis A	☐ Hepatitis B	☐ Influenza	☐ Pneumonia	☐ Tetanus	☐ Other
Date:	Date:	Date:	Date:	Date:	Date:

HOSPITALIZATIONS:

Date	Reason for Hospitalization	Name of Hospital
/ /		
/ /		
/ /		
/ /		
/ /		

FAMILY HISTORY: *Fill in health information about your family.*

	Age	Health Problems	If Diseased - Cause of Death	Age	Has any blood relative had	Yes
Father			☐		Tuberculosis	☐
Mother			☐		Heart Disease	☐
Brother / Sister			☐		High Blood Pressure	☐
Brother / Sister			☐		Alcoholism	☐
Brother / Sister			☐		Kidney Disease	☐
Brother / Sister			☐		Diabetes	☐
Children			☐		Strokes	☐
Boy / Girl			☐		Epilepsy	☐
Boy / Girl			☐		Mental Illness	☐
Boy / Girl			☐		Allergies	☐

Turn over to complete

PATIENT HEALTH QUESTIONNAIRE

Recently have you been affected by any of the following ? *ONLY Check (✓) if it applies to you.*

GENERAL:

- ☐ Fatigue
- ☐ Loss / Change of Appetite
- ☐ Loss of Weight
- ☐ Gain of Weight
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Intolerance to Heat
- ☐ Intolerance to Cold
- ☐ Any Rashes or Skin Trouble
- ☐ Fainting
- ☐ Increased thirst or urination
- ☐ Difficulty Sleeping
- ☐ Bleeding Tendency
- ☐ Sexual dysfunction
- ☐ Worried about Sex T Diseases
- ☐ Forced to have sex
- ☐ Other

HEAD & NECK:

- ☐ Headaches
- ☐ Eye trouble
- ☐ Hearing difficulty
- ☐ Earaches
- ☐ Sinus trouble
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Hay fever
- ☐ Dental trouble
- ☐ Sore tongue
- ☐ Frequent colds
- ☐ Sore throat
- ☐ Lumps in neck
- ☐ Neck pain
- ☐ Other

RESPIRATORY:

- ☐ Cough
- ☐ Sputum
- ☐ Bloody sputum
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Date of last TB skin test
- ☐ Cigarette smoker #/day _____
- ☐ Date of last Tetanus _____
- ☐ Other

CARDIOVASCULAR:

- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Leg cramps while walking
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Varicose Veins
- ☐ Snoring
- ☐ Date of last EKG _____
- ☐ High blood pressure
- ☐ Other

DIGESTIVE:

- ☐ Difficulty swallowing
- ☐ Heart burn
- ☐ Nausea
- ☐ Vomiting
- ☐ On a special diet
- ☐ Abdominal pain
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dairy product intolerance
- ☐ Bloody stools
- ☐ Black stools
- ☐ Do you take laxatives ?
- ☐ Do foods cause indigestion ?
- ☐ Other

GENITO-URINARY: MEN & WOMEN

- ☐ Frequency of urination
- ☐ Painful urination
- ☐ Kidney or Bladder Stones
- ☐ Hx of > than 4 sexual partners
- ☐ Change in appearance of urine
- ☐ Incontinence
- ☐ Sores in the genital area
- ☐ History of STD
- ☐ Get up at night to urinate Number of times
- ☐ Sex before age 18
- ☐ Other

MUSCLE & JOINT:

- ☐ Pain, stiffness or joint swelling
- ☐ Limitation of joint movement
- ☐ Disabling night leg cramps
- ☐ History of broken bones?
- ☐ Foot trouble
- ☐ Knee trouble
- ☐ Back pain
- ☐ Deformities
- ☐ Hip pain

NERVOUS & PSYCHIATRIC SYSTEM:

- ☐ Forgetfulness
- ☐ Nervousness
- ☐ Depression
- ☐ Spells of any kind
- ☐ Recent significant change in life
- ☐ Special stresses in your life
- ☐ Abnormal sensations
- ☐ Loss of balance
- ☐ Clumsiness
- ☐ Muscle weakness
- ☐ Financial hardships
- ☐ I am not a happy person
- ☐ Difficulty walking
- ☐ Tremors
- ☐ Dizziness
- ☐ Fainting
- ☐ Abusive relationship
- ☐ Frightened of partner

GENITO-URINARY - WOMEN ONLY:

- ☐ Irregular menstruation
- ☐ Painful menstruation
- ☐ Very heavy periods
- ☐ Bleeding between periods
- ☐ Date of Pap smear
- ☐ Date of mammogram
- ☐ Type of Birth Control
- ☐ Passed the menopause
- ☐ Abnormal vaginal discharge
- ☐ Taking Hormones or BCP
- ☐ Trouble with breasts
- ☐ # pregnancies
- ☐ # miscarriages
- ☐ I am not sexually satisfied

GENITO-URINARY - MEN ONLY:

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Breast lump or tenderness
- ☐ I am not sexually satisfied
- ☐ Other

OTHER:

- ☐ Exercise: Type: Mins each day x / wk
- ☐ Caffeine intake / day: Cola Coffee Tea
- Living Will? ☐ Yes ☐ No
- Advanced Directives? ☐ Yes ☐ No
- ☐ Use of substances / day Alcohol Other
- ☐ Memory blackouts with drinking
- ☐ History of substance abuse
- ☐ Married ☐ Single ☐ Widowed
- ☐ Dangerous sport or vehicle
- ☐ Hazardous substances exposure
- Your occupation
- Your hobbies
- Wear Seatbelts? ☐ Yes ☐ No
- ☐ Organ donation requested
- ☐ Wear helmet

Turn over to complete