Patient Health Questionnaire

PATIENT NAME: _____ OCCUPATION: _____

PAST MEDICAL HISTORY:
Check any conditions you are currently being treated for or have been treated for in the past.

___Allergies, what type _____
___Anemia
___Angina (Chest Pain)
___Anxiety
___Arthritis, what type _____
___Asthma
___Cancer
___Cardiac Conditions, what type _____
___Cardiac Pacemaker
___Chemical Dependency
___Circulation Problems
___Currently pregnant
___Depression
___Diabetes
___Dizzy Spells
___Emphysema/Bronchitis
___ Fractures
___ Gall Bladder Problems
___ Hepatitis
___ High Blood Pressure
___ Incontinence
___ Kidney Problems
___ Metal Implants
___ Multiple Sclerosis
___ Osteoporosis
___ Parkinson's
___ Rheumatoid Arthritis
___ Seizures/Epilepsy
___ Speech Problems
___ Strokes
___ Thyroid Disease ___Hypo ___Hyper
___ Tuberculosis
___ Vision Problems
___ Other conditions not listed_____
_____
_____

PAST SURGICAL HISTORY:
Please list approximate dates, types of surgery you've had or reasons for hospitalization.

DATE (Month/Year)	**PROCEDURE/REASON FOR HOSPITALIZATION**
_____	_____
_____	_____
_____	_____
_____	_____

PAST INJURIES:
Please list approximate dates, any/all injuries you've had. (ex. accidents, broken bones)

DATE (Month/Year)	**PROCEDURE/REASON FOR INJURY**
_____	_____
_____	_____
_____	_____

MEDICARE PATIENTS:

Height: _____ **Weight:_____**

FALL HISTORY:
Have you had an injury as a result of a fall in the past year? _____Yes _____No
Have you had two or more falls in the past year? _____Yes _____No

OVER →

PLEASE LIST ALL PRESCRIPTION MEDICATIONS AND OVER THE COUNTER MEDICATIONS INCLUDING VITAMIN SUPPLEMENTS YOU ARE CURRENTLY TAKING:

NAME:	DOSAGE:	FREQUENCY: (ex. 1x/day)	ROUTE: (ex. oral, injection, topical)	REASON FOR TAKING: