Patient Health Questionnaire

PATIENT NAME: _____ DATE: _____

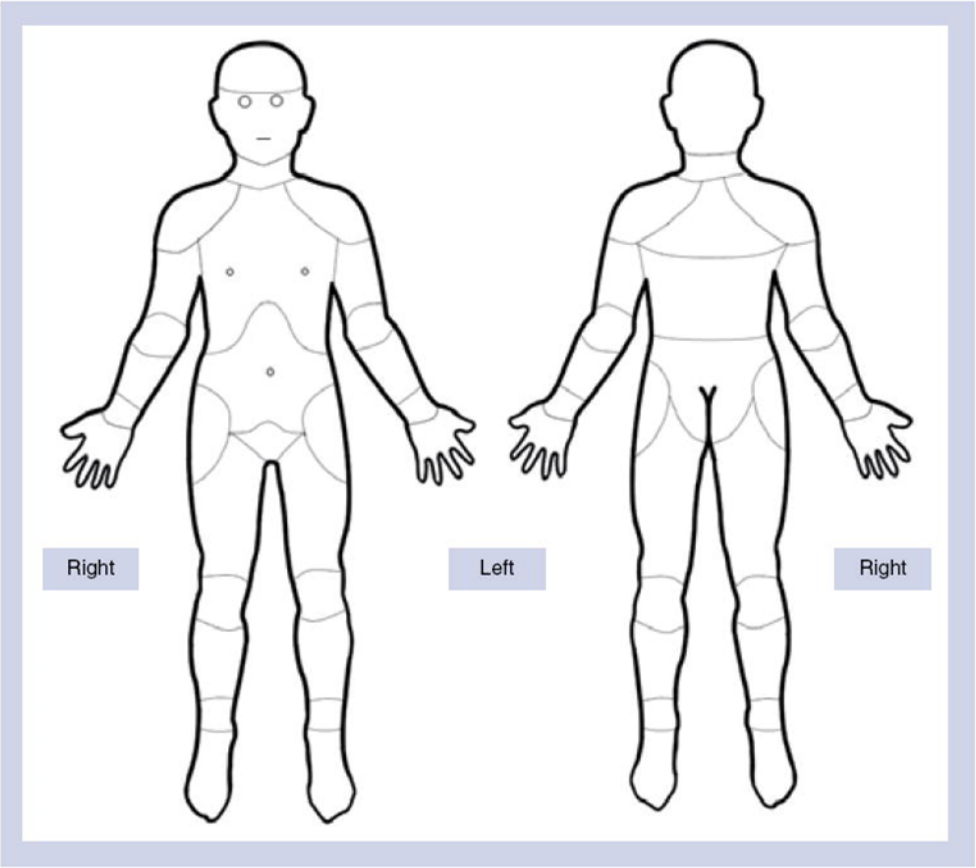
PAST MEDICAL HISTORY:
Check any conditions you are currently being treated for or have been treated for in the past.

___ Allergies
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Autoimmune Disorder
___ Cancer
___ Cardiac Conditions
___ Cardiac Pacemaker
___ Chemical Dependency
___ Circulation Problems
___ Covid-19
___ Currently Pregnant
___ Depression
___ Other Conditions
_____
_____

___ Diabetes
___ Dizzy Spells
___ Emphysema/Bronchitis
___ Fibromyalgia
___ Fractures
___ Gall Bladder Problems
___ Headaches
___ Hearing Impairment
___ Hepatitis
___ High Cholesterol
___ High/Low Blood Pressure
___ HIV/AIDS
___ Incontinence
___ Kidney Problems

___ Metal Implants
___ MRSA
___ Multiple Sclerosis
___ Muscular Disease
___ Osteoporosis
___ Parkinson's
___ Rheumatoid Arthritis
___ Seizures/Epilepsy
___ Smoking
___ Speech Problems
___ Strokes
___ Thyroid Disease
___Hypo ____ Hyper
___ Tuberculosis
___ Vision Problems

Please mark on the diagram below any current area of pain or complaints feel free to describe these symptoms



PLEASE SEE OTHER SIDE

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 have had. (ex. accidents, broken bones)

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

MEDICARE PATIENTS:

Height: _____ **Weight:_____**

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

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:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
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