

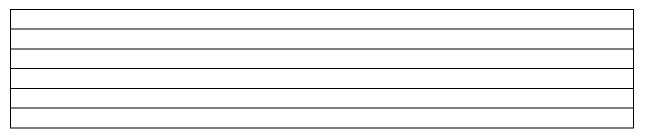
Patient Health Questionnaire

# Past Medical History

Do you currently have or been treated in the past for any of the following medical conditions?

Allergies	Varicose veins	Heart murmu
Aneurysm	Wounds/sores	Heart attack
Carotid stenosis	Peripheral vascular	Chest pain
Arthritis	disease	Stroke
COPD	Heart failure	Blood clot
Asthma	High blood pressure	Hepatitis
Cancer	High cholesterol	HIV/AIDS
Diabetes	Kidney disease	Dialysis
Thyroid disease	Kidney failure	

Please list any other disease or medical condition for which you are being treated or have been treated in the past:



### Prior Surgeries or Hospitalizations

#### Please list any prior surgeries and/or procedures that you have had

Date	Reason for Surgery/Hospitalization	List any complications

#### Family History

Please indicate if any blood relatives have had any of the following conditions (Indicate relationship)

\_\_\_\_\_ Diabetes

- \_\_\_\_\_ High blood pressure \_\_\_\_\_ Perip
- \_\_\_\_\_ 0 1
- \_\_\_\_\_ Heart disease/heart attack
- \_\_\_\_\_ Aneurysm
- \_\_\_\_\_ Stroke

- \_\_\_\_\_ Varicose veins
  - \_\_\_\_\_ Peripheral vascular disease
- \_\_\_\_\_ Kidney disease
  - \_\_\_\_\_ Blood clots
    - \_\_\_\_\_ Cancer

# Allergies

Allergy	What is your reaction

### Family History

Please indicate if any blood relatives have had any of the following conditions (Indicate relationship)

Diabetes	Varicose veins
High blood pressure	Peripheral vascular disease
Heart disease/heart attack	Kidney disease
Aneurysm	Blood clots
Stroke	Cancer

# Social History

- \_\_\_\_\_ Do you currently smoke
- \_\_\_\_\_ If yes for how long
- \_\_\_\_\_ How many packs per day
- \_\_\_\_\_ Do you drink alcohol
- \_\_\_\_\_If yes how many drinks per week
- \_\_\_\_\_ Any history of illicit drug use

# Medications

Medication/Vitamin/Supplement	Dosage	Frequency

#### Please list your current Medications/Vitamins/Supplements

# Review of Systems

General		
Fatigue	Significant weight loss	Chills
Significant weight gain	Fever	
Vascular (Circulation)		
Leg pain with standing	Leg pain with walking	Skin discoloration
Leg pain with sitting	Leg Swelling	

Cardiac (Heart)

Chest pain	Fainting	Blood thinner
Anemia	Blood clot	Anemia
Women's Health		
Frequent urination	Pelvic pressure	Pain with sex
Pelvic pain	Prolonged bleeding	
Renal (Kidney)		
Frequent urination	Blood in urine	
Flank pain	Kidney stones	
Neurologic (Brain)		
Weakness	Seizures	TIA
Headaches	Stroke	
Respiratory (Lungs)		
Cough	Shortness of breath	Snooring
Wheezing	Sleep apnea	
Eyes/Ears/Nose and Throat		
Glasses/contacts	Nosebleeds	Painful teeth
Blurred vision	Deafness	Vision changes
Hoarseness	Mouth sores	Vision loss/blindness
Psychiatric		
Difficulty concentrating	Change in sleeping habits	Anxiety
Tension	Nervousness	Feelings of hopelessness
Gastrointestinal		nopelessness
Constipation	Stomach ulcers	Heartburn
Diarrhea	Abdominal pain	
Musculoskeletal/Skin		
Dryness	Joint pain	Muscle soreness
Skin discoloration	Joint swelling	

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Muscle weakness

Endocrine

\_\_\_\_\_ Abnormal hair loss \_\_\_\_\_ Heat/cold intolerance \_\_\_\_\_ Weight gain/loss

Patient/Guardian signature: \_\_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ Relation to the patient: \_\_\_\_\_