

Patient Health Questionnaire - page 2

Please Complete Accurately

For Internal Use Only

Patient Name _____ Date _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ 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 Allergies
Elbow/Upper Arm Pain Kidney Disorders Depression
Wrist Pain Bladder Infection Systemic Lupus
Hand Pain Painful Urination Epilepsy
Hip/Upper Leg Pain Loss of Bladder Control Dermatitis/Eczema/Rash
Knee/Lower Leg Pain Prostate Problems HIV/AIDS
Ankle/Foot Pain Abnormal Weight Gain/Loss
Jaw Pain Loss of Appetite
Joint Swelling/Stiffness Abdominal Pain Females Only
Arthritis Ulcer Birth Control Pills
Rheumatoid Arthritis Hepatitis Hormonal Replacement
Pregnancy
General Fatigue Cancer Other Health Problems/Issues
Muscular Incoordination Tumor
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 _____