

**PATIENT HEALTH QUESTIONNAIRE**

**STAFF USE ONLY:**

Date: \_\_\_\_\_

Acct. #: \_\_\_\_\_

Chart #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Any additional physicians to whom you want report(s) sent? \_\_\_\_\_

**CHIEF COMPLAINT:**

(What is the reason for your consultation):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

(location, quality, severity, duration, timing, context, modifying factors, associated signs & symptoms):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CARDIOVASCULAR & PULMONARY REVIEW OF SYSTEMS:**

Yes	No	Symptom	Comments
___	___	chest discomfort	_____
___	___	palpatations, like a skipped beat or flip flop	_____
___	___	heart racing	_____
___	___	lightheadedness (dizziness)	_____
___	___	fainting (blackouts)	_____
___	___	cramping of buttock or leg with walking	_____
___	___	cold legs or feet	_____
___	___	numbness/tingling of hands or feet	_____
___	___	swelling of the legs or feet	_____
___	___	paleness of the legs or feet when elevated	_____
___	___	fragile, shiny or hairless skin on legs or feet	_____
___	___	sores on legs or feet that heal poorly	_____
___	___	other	_____
___	___	cough	_____
___	___	shortness of breath with exertion	_____
___	___	wake up at night short of breath	_____
___	___	unable to lie flat due to shortness of breath	_____
___	___	fall asleep sitting/reading/watching TV	_____
___	___	fall asleep sitting, inactive in public place	_____
___	___	fall asleep driving/passenger in a car	_____
___	___	fall asleep talking to someone	_____
___	___	fall asleep after lunch without alcohol	_____
___	___	other	_____
___	___	snoring or feeling like breathing stops when sleeping	_____

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**PAST MEDICAL HISTORY:**

<u>Yes</u>	<u>No</u>	<u>Condition</u>	<u>Comments</u>
___	___	angina	_____
___	___	coronary artery disease	_____
___	___	carotid artery disease	_____
___	___	stroke/TIA	_____
___	___	peripheral artery (vascular) disease	_____
___	___	varicose veins	_____
___	___	heart murmurs/valvular heart disease	_____
___	___	heart failure	_____
___	___	cardiomyopathy	_____
___	___	heart arrhythmia	_____
___	___	high blood pressure	_____
___	___	high cholesterol	_____
___	___	diabetes	_____
___	___	menopause	_____
___	___	sleep apnea	_____
___	___	GERD or gastrointestinal disorder	_____
___	___	COPD/asthma	_____
___	___	other lung/respiratory condition	_____
___	___	liver disease	_____
___	___	kidney disease	_____
___	___	arthritis	_____
___	___	cancer	_____
___	___	blood disorder, including anemia or bleeding problem	_____
___	___	other	_____

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**PAST SURGICAL HISTORY:**

<u>Yes</u>	<u>No</u>	<u>Surgery</u>	<u>When</u>
___	___	coronary artery (heart) by-pass	_____
___	___	heart valve	_____
___	___	pacemaker	_____
___	___	defibrillator	_____
___	___	carotid artery surgery	_____
___	___	peripheral vascular surgery	_____
___	___	gallbladder	_____



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**SOCIAL HISTORY:**

Marital status: \_\_\_\_\_ Smoke: \_\_\_yes \_\_\_no how much? \_\_\_\_\_  
Occupation: \_\_\_\_\_ Drink alcohol: \_\_\_yes \_\_\_no how much? \_\_\_\_\_  
Education: \_\_\_\_\_ Exercise: \_\_\_yes \_\_\_no how much? \_\_\_\_\_  
Caffeine: \_\_\_yes \_\_\_no how much? \_\_\_\_\_

**FAMILY HISTORY:**

\_\_\_yes \_\_\_no History of heart attack or stroke in parent(s) or sibling(s) at an age younger than 55 for males or 65 for females.

	<u>Alive/Age</u>	<u>Deceased/Age</u>	<u>Medical Conditions</u>
Mother	_____	_____	_____
Father	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Children	_____	_____	_____

**REVIEW OF SYSTEMS:**

Yes	No	Symptom	Comments
<b>Constitutional</b>			
___	___	fatigue	_____
___	___	recent weight loss	_____
___	___	recent weight gain	_____
___	___	fever or chills	_____
___	___	loss of appetite	_____
___	___	other	_____
<b>Eyes</b>			
___	___	change in vision	_____
___	___	other	_____
<b>Ears, Nose, Mouth, Throat</b>			
___	___	difficulty hearing	_____
___	___	other	_____
<b>Gastrointestinal</b>			
___	___	abdominal bloating/increased girth	_____
___	___	stomach or abdominal discomfort	_____
___	___	diarrhea	_____
___	___	constipation	_____
___	___	bloody or tarry stools	_____
___	___	other	_____

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**REVIEW OF SYSTEMS (Continued):**

<u>Yes</u>	<u>No</u>	<u>Symptom</u>		<u>Comments</u>
			<b>Genitourinary</b>	
___	___	frequent urination		_____
___	___	difficult starting urine		_____
___	___	decreased urine stream		_____
___	___	erectile dysfunction		_____
___	___	loss of libido		_____
___	___	menopause (natural)		_____
___	___	menopause (surgical) (ovaries?)		_____
___	___	use of estrogen (# of years) (type of hormone)		_____
___	___	currently pregnant		_____
___	___	other		_____
			<b>Musculoskeletal</b>	
___	___	joint pain		_____
___	___	muscle pain		_____
___	___	other		_____
			<b>Integumentary (skin/breast)</b>	
___	___	easy bruising		_____
___	___	other		_____
			<b>Neurological</b>	
___	___	headaches		_____
___	___	transient localized numbness or weakness		_____
___	___	transient slurred speech or loss of vision		_____
___	___	other		_____
			<b>Psychiatric</b>	
___	___	depression		_____
___	___	anxiety		_____
___	___	feel under stress		_____
___	___	other		_____
			<b>Hematologic/Lymphatic</b>	
___	___	blood disorder		_____
___	___	anemia or bleeding problem		_____
___	___	other		_____
			<b>Endocrine/Allergic/Immumologic</b>	
___	___	allergies		_____
___	___	immune deficiencies		_____
___	___	other		_____

Nurses Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MD/PA/NP Signature: \_\_\_\_\_ Date: \_\_\_\_\_