FAMILY MEDICAL GROUP, P.A.

PATIENT HEALTH QUESTIONNAIRE

Today's Date:______________ Name:_____________________________________ Maiden: ____________________
Date of Birth:_______________________ Age:_________ Sex: M F Race:_______________________________
Marital Status: S M D W SEP Religion:___________________________________ Hand: L R
Informant: ( ) Patient ( ) Other Referral: ( )Self ( ) Other____
Date of Last Physical Exam:______________ Reason for Today's Visit:____________________________________

DRUG ALLERGIES	MEDICATIONS – including those without prescription

SYMPTOMS: check those you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weight Gain/Loss

Gastrointestinal
- ☐ Appetite Decreased/Increased
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Eye, Ear, Nose, Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Flashes/ Halos

Muscle/Joint/Bone
Pain, Numbness, Weakness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

Skin
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Changes in Moles
- ☐ Rash

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Women Only — Date
- ☐ Abnormal Pap __________
- ☐ Bleeding Bet. Periods
- ☐ Breast Exam __________
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Mammogram Exam __________
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Pap Smear Exam __________
- ☐ Vaginal Discharge

Men Only
- ☐ Breast Lump
- ☐ Erection Difficulty
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Prostate Problems
- ☐ PSA Test Date__________
- ☐ Sores on Penis

Women & Men — Date
- ☐ Cholesterol Test ___________
- ☐ Colonoscopy ___________
- ☐ Dexa Exam ___________
- ☐ Eye Exam ___________
- ☐ Hemocult Exam ___________
- ☐ Rectal Exam ___________
- ☐ TB Test ___________

Menarche: ______________ Date of Last Period: ____________ Currently Pregnant: Y N Total Pregnancies:_________
Full Term:________ Live Births:_________ C-Sections_________ Abortions/Miscarriages:_________
Age at First Delivery: ________ Contraception Method:______________________Menopause: Y N Date:_____________

CONDITIONS: check those you currently have or have been diagnosed with.

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Pressure Prob.
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gall Bladder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migrane Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Nervous Disorder
- ☐ Mumps
- ☐ Parasites
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Syphillis
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Whooping Cough

DISABILITY: list the conditions and the year you became disabled. YEAR

______________________________ ____________
______________________________ ____________

IMMUNIZATIONS:

- ☐ Chicken Pox
- ☐ MMR
- ☐ DPT
- ☐ Oral Polio
- ☐ Hepatitis A&B Series
- ☐ TD
- ☐ HIB
- ☐ Other______________
- ☐ Influenza

HOSPITAL ADMISSIONS – do not list pregnancies		BLOOD TRANSFUSIONS	
YEAR	ILLNESS OR OPERATION	YEAR	OUTCOME

HEALTH, OCCUPATION & SOCIAL HABITS: check the substances you currently use and how much.

- ☐ Alcohol______________
- ☐ Caffeine______________
- ☐ Nicotine/Cigarettes/Chewing Tobacco ______________
- ☐ Recreational Drugs______________ ______________
- ☐ Exercise______________
- ☐ Hobbies______________

Living Arrangements: ☐ Alone ☐ Spouse ☐ Family ☐ Other______________

Diet: Fat Content: Hi Med Low Salt Content: Hi Med Low

Safety: ☐ Seat Belts ☐ Child Restraint Transportation: ☐ Drive ☐ Driven by Other ☐ Community Transport

Education: 1 2 3 4 5 6 7 8 9 10 11 12 (HS Grad) ☐ College 1 2 3 4 ☐ Post Graduate Degree______________
Occupation: ______________ (if retired state previous occupation)
Check if your job exposes you to the following: ☐ Hazardous Substances ☐ Heavy Lifting ☐ Stress

Do Not Write Below This Line – Staff Use Only

FAMILY HISTORY

RELATIVE	Alive	Deceased	Cause	CA	CAD	DM	HTN	PSYCH	Other
Father									
Mother									
Brother (s) #:									
Sister (s) #:									

Signature:______________MD Signature:______________APRN