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PATIENT HEALTH QUESTIONNAIRE

Name:_____ Age:_____ Marital Status:_____ Date:_____
Height:_____ Weight:_____
General Health is ?_____ Have you had a cold or flu in the past month?_____
Are symptoms still present?_____

HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAD ANY OF THE FOLLOWING CONDITIONS:

	YES	NO		YES	NO
Heart Trouble/Congestive Heart Failure			Glaucoma or Eye Disorder		
Heart Attack/ Chest Pain			Visual Disturbances		
Endocarditis			Other Eye Problems		
Palpitations or Irregular Pulse			Hepatitis A		
Extra Heart Beats			Hepatitis B or C		
Mitral Valve Prolapse			Jaundice		
Stroke or TIA (Transient Ischemic Attack)			Gallstones or Gallbladder Trouble		
Blood Disease			Cirrhosis of the Liver		
High Blood Pressure			Alcoholism		
Abnormal Electrocardiogram(EKG)			Esophageal Varices		
Rheumatic Fever			Frequent Indigestion		
Shortness of Breath			Ulcers		
Asthma			Gastritis		
Bronchitis			Colitis/Crohn's Disease		
Tuberculosis			Constipation		
Pneumonia			Vomiting Blood		
Smoker's Cough			Tarry or Bloody Bowel Movements		
Emphysema			Hemmorrhoids		
Coughing or Spitting Blood			Thyroid Disease		
Hay Fever or Other Allergies			Diabetes		
Frequent Respiratory Infections			Skin Disorders/Rashes		
Nervous Disorder			Arthritis		
Insomnia			Fracture of Neck or Spine		
Drug Addiction/Habit			Bleeding Tendency or Disorder		
Psychiatric Hospitalization or Care			Blood Infection		
AIDS or HIV Infection			Airway Obstruction (Nasal)		
Herpes/Syphillis/or Gonorrhea			Breast Cysts, Tumors, Abscesses		
Cancer			Nipple Discharge		
Kidney/Bladder Problems			Blood Transfusion		
Seizures/ Seizure Disorder					

PATIENT HEALTH QUESTIONNAIRE

1. Do you have **allergic reactions** to any medication? YES NO If so, to which meds? _____
2. Do you react abnormally to any medication? YES NO If so, to which meds? _____
3. Do you have an **allergic reaction** to contrast material? YES NO
4. Do you have any **family history** of cancer, heart trouble, stroke, diabetes, or kidney problems? YES NO
   If so, which family member(s)?_____
5. Do you have **cocktails** regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? YES NO If so how much?_____
6. Do you **smoke**? YES NO If so how much? _____
7. Do you have a history of **excessive bruising or bleeding** following surgery or minor trauma (including tooth extractions or mouth trauma) ? YES NO
8. Have you, or your blood relatives required blood transfusions following previous surgery or trauma? YES NO
   If so, please specify:_____
9. Are you **pregnant**? YES NO When was your last menstrual period? ____/____/____
   Was it normal? YES NO
10. How many pregnancies? _____ Births:_____ Breast fed? YES NO How Long?_____months
11. Have you ever been on Cortisone or steroid treatment? YES NO If so, when? _____3
12. Pleas list **all present medications and dosages**, including Birth Control Pills, Hormones, Vitamins, and Over-the-Counter medications:_____
13. Do you take Diuretics? YES NO If so, what? _____
14. When was your last Physical Exam? ____/____/____ By Whom: Dr._____
15. When was your last Eye Exam? ____/____/____ By Whom: Dr._____
16. When was your last Electrocardiogram(EKG) and where?_____
17. When was your last Chest X-ray and where?_____
18. Please list **ALL** prior hospitalizations and surgical operation , including date and reason:

HOSPITALIZATIONS:

Location	Date	Reasons

Surgical Operations:

Location	Date	Reasons

Drug History: Taken In Last 6 Months:

___ STEROIDS (CORTISONE, ACTH, ETC)
___ ANTIBIOTICS
___ DIABETIC MEDICATION
___ THYROID MEDICATION
___ ARTHRITIS MEDICATION
___ TRANQUILIZERS
___ NARCOTICS
___ BLOOD PRESSURE MEDICATION
___ HEART MEDICATION
___ ACCUTANE

Patient's Signature:_____ Date: _____/_____/_____