Dr. David Davis
Dr. Nikhil Joshi & Dr. Tariq Yousuf

Patient Health Questionnaire

NAME: _____ **DATE**: _____

Please answer the following questions to the best of your ability. This will help your doctor know more about you. These answers, of course, are confidential.

Marital Status (Married,Single,Divorced,Widowed) _____

Do you have children? ☐ Yes ☐ No If So, How Many? _____

Your Preferred Language is: _____

Your Race/Ethnicity is: _____

Are you retired? ☐ Yes ☐ No

If retired, what type of work did you do? _____

If currently employed, what type of work do you do? _____

Do you smoke? ☐ Yes ☐ No, but used to ☐ Never

If you used to smoke, when did you quit? _____

How many packs of cigarettes do you or did you smoke and for how many years?

(Example: 1 pack/day for 20 years) _____

Do you drink alcohol? ☐ Yes ☐ No, but used to ☐ Never

If you used to drink, when did you quit? _____

How much do you or did you drink in an average week?

☐ 0-1 drinks or beers/week, ☐ 1-5, ☐ 6-10, ☐ more than 10

Do you have a history of Drug Use/Abuse? ☐ Yes ☐ No

Are you following any special diet? ☐ Yes ☐ No If yes, please specify:
_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, list please:_____

Are you allergic to iodine, shrimp, or shellfish? ☐ Yes ☐ No

Have you ever received x-ray contrast in your vein for any reason (myelogram, kidney series, CAT scan, etc.)?

☐ Yes ☐ No If yes, did you have a problem with this? _____

Have you had a blood transfusion? ☐ Yes ☐ No If so, When? _____

Have you had any operations or surgeries in the past? ☐ Yes ☐ No

If yes, what type and approximate date _____

Please list all medications (prescription and non-prescription) you are supposed to be taking at home (see example).

	NAME	DOSE/STRENGTH	NUMBER TAKEN AT TIME OF DAY
EXAMPLE:	**Lasix**	**40mg.**	**2 at 9 a.m., 1 at 6:00 p.m.**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____

Family medical history:

Father's age _____, or age at death _____ cause of death _____.

Mother's age _____, or age at death _____ cause of death _____.

Sibling, (brother or sister), age, or age at death:

1) _____, _____ age, _____ age at death
2) _____, _____ age, _____ age at death
3) _____, _____ age, _____ age at death
4) _____, _____ age, _____ age at death
5) _____, _____ age, _____ age at death

Medical Problems	**Father**	**Mother**	**Sibling (s)**
1) Heart attack	_____	_____	_____
2) Stroke	_____	_____	_____
3) Diabetes	_____	_____	_____
4) High blood pressure	_____	_____	_____
5) Angina	_____	_____	_____

Other family members with heart problems:
(Example: Paternal uncle, age 55, has a pacemaker.)

_____

_____

_____

_____

_____

_____

Please answer the following questions that relate to health problems that <u>you</u> currently have or have had in the past. Please use a check mark under the "YES" or "NO" column.

	YES	NO
Headaches		
Fatigue or Weakness		
Blurred vision / Double vision/ Eye pain (circle all that apply)		
Sore throat / Dry mouth (circle all that apply)		
Weight Loss / Weight Gain		
Heat Intolerance / Cold Intolerance		
Coughing blood		
Cough / Wheeze / Asthma (circle all that apply)		
Emphysema or COPD (circle all that apply)		
Chest Pain		
Palpitations or Arrhythmia		
Nausea or Vomiting (circle one)		
Diarrhea or Constipation (circle one)		
Abdominal pain / Heart burn (circle all that apply)		
Abnormal bleeding or Bruising		
Blood in urine / difficulty urinating (circle all that apply)		
Back pain / Muscle Weakness / (circle all that apply)		
Arthritis		
Skin hives / Abnormal skin rash (circle all that apply)		
Syncope / Passing out Episodes		
Numbness		
Seizures		
Dizziness		
Stress / Anxiety / Depression (circle all that apply)		
Swelling in Legs / Edema		
Diabetes		
Thyroid Disease		
High Cholesterol		
History of Rheumatic Fever		