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Internal Medicine & Cardiovascular Disease

PATIENT HEALTH QUESTIONNAIRE

Please take time to provide the following information for our files. This information is treated with strict confidentiality & will help us provide a comprehensive assessment of your health care needs

NAME ---------- DATE OF BIRTH ---------- DATE ----------

CHIEF COMPLAINTS / REASONS FOR VISIT----------
---------- ----------

MEDICAL ILNESSES *(Diseases you now have or have had in the past)*

Condition	Onset Date	Condition	Onset Date	Condition	Onset Date
☐ Migraine Headache	----------	☐ Chronic Heartburn	----------	☐ Diabetes	----------
☐ Seizures or Convulsions	----------	☐ Peptic Ulcer	----------	☐ Thyroid Disorder	----------
☐ Stroke	----------	☐ Hepatitis	----------	☐ High cholesterol	----------
☐ Polio	----------	☐ Liver Cirrhosis	----------		----------
☐ Glaucoma	----------	☐ Gall Stones	----------	☐ Gonorrhea	----------
☐ Cataract	----------	☐ Irritable Bowel	----------	☐ Syphilis	----------
☐ Blindness	----------	☐ Inflammatory Bowel	----------	☐ HIV Infection	----------
☐ Recurrent ear infection	----------			☐ Herpes Infection	----------
☐ Deafness	----------	☐ Kidney Stones	----------	☐ Other VD	
☐ Hay Fever, Allergic nose	----------	☐ Recurrent Urine Infection	----------		----------
☐ Recurrent Sinusitis	----------	☐ Other Kidney Disease	----------	☐ Depression	----------
				☐ Nervous Breakdown	----------
☐ Asthma	----------	☐ Arthritis	----------	☐ Emotional Problems	
☐ Chronic Bronchitis	----------	☐ Gout	----------	***Women***	----------
☐ Emphysema	----------	☐ Broken Bones	----------	☐ Menstrual Difficulties	----------
☐ Tuberculosis	----------			☐ Abnormal PAP	----------
		☐ Varicose Veins	----------	☐ Ovarian Cyst(s)	----------
☐ Heart Murmur	----------	☐ Blood Clots	----------	☐ Breast Lump(s)	
☐ Heart Attack	----------	☐ Bleeding Disorder	----------	***Men***	----------
☐ Angina	----------	☐ Anemia	----------	☐ Prostatism	
☐ Enlarged Heart	----------			*Others*	----------
☐ Rheumatic Fever	----------	☐ Cancer----------	----------	☐ ----------	----------
☐ High Blood Pressure	----------	☐ Skin Disorder	----------	☐ ----------	----------

SURGICAL HISTORY *(List surgical procedures starting from most recent ones)*

Procedure	Date	Procedure	Date	Procedure	Date
1. ----------	----------	3. ----------	----------	5. ----------	----------
2. ----------	----------	4. ----------	----------	6. ----------	----------

HOSPITALIZATION HISTORY *(List hospital admissions starting from most recent ones)*

Reason	Date	Reason	Date	Reason	Date
1. ----------	----------	3. ----------	----------	5. ----------	----------
2. ----------	----------	4. ----------	----------	6. ----------	----------

ALLERGIES *(Include drugs, food, chemicals, insects, etc…)*

Item & Type of Reaction	Drug Name & Dose
1. ----------	4. ----------
2. ----------	5. ----------
3. ----------	6. ----------

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CURRENT MEDICATION *(List medicines you take now including vitamins, birth control pills, & over the counter drugs)*

Drug Name & Dose	Drug Name & Dose
1. ----------	6. ----------
2. ----------	7. ----------
3. ----------	8. ----------
4. ----------	9. ----------
5. ----------	10. ----------

INVESTIGATION HISTORY *(List recent CT, MRI, ECHO, ultrasound, stress test, nuclear test, angiogram, etc….)*

Procedure	Date	Procedure	Date	Procedure	Date
1. ----------	----------	3. ----------	----------	5. ----------	----------
2. ----------	----------	4. ----------	----------	6. ----------	----------

FAMILY HISTORY (*Please complete the following information about your relatives*)

	Living	Dead	Age	Chronic Conditions/Cause of death
Father				
Mother				
Brothers (No.-----) & Sisters (No. -----)				
Spouse				
Children (No. -----)				

Please check all conditions identified in your relatives and note which relatives are affected

Condition	Relation	Condition	Relation	Condition	Relation
☐ Migraine Headache	----------	☐ Heart Attack	----------	☐ Cancer	----------
☐ Seizures or Convulsions	----------	☐ Angina	----------	☐ Diabetes	----------
☐ Stroke	----------	☐ High Blood Pressure	----------	☐ Mental Illness	----------
☐ Glaucoma	----------	☐ Liver Disease	----------	☐ Birth Defects	----------
☐ Asthma	----------	☐ Bowel Disease	----------	☐ ----------	----------
☐ Emphysema	----------	☐ Kidney Disease	----------	☐ ----------	----------
☐ Tuberculosis	----------	☐ Bleeding Disorder	----------	☐ ----------	----------

SOCIAL HISTORY (Please complete the following information about yourself)

Current Occupation: ----------

Education Completed: ◘ Grade: ---------- ◘ High School ----------
◘ College: ------ years, degree/major ---------- ◘ Post-Graduate ----------

Marital Status: ◘ Single ◘ Married -------yrs ◘ Separated --------yrs ◘ Divorced -------yrs ◘ Widowed ---------yrs
Married -------- time(s): #1: --------yrs, --------children #2: --------yrs, --------children #3: --------yrs, --------children

Personal Habits: (check all that apply)
☐ Currently use tobacco: Type: ◘ Cigarettes ◘ Cigars ◘Pipe ◘ Smokeless tobacco Amount /day: ------- Years -------

☐ Former smoker: Amount /day: ------- Years ------- Quit Date: ---------- ☐ Exposed to second-hand smoke

☐ Consume Alcohol: Type: ---------- Amount /day: ---------- Years ----------

☐ Use recreational drugs: Type: ---------- Frequency: ---------- Years ----------

☐ Exercise Regularly: Type: ---------- Frequency: ---------- Years ----------

Sexual History: ☐ Multiple sex partners ☐ Prefer opposite sex ☐ Prefer same-sex relationships

REVIEW OF SYSTEMS *(Please check never, past, or now for each problem. Past is anytime longer than six month. Check NA if the entire section is non applicable. Use the space in the 4th page to add comments or explanations))*

NEVER	PAST	NOW	Have you ever had
GENERAL			☐ **NA**
☐	☐	☐	Unexplained weight loss or weight gain
☐	☐	☐	Excessive fatigue
☐	☐	☐	Prolonged fever/chills
☐	☐	☐	Other:
HEAD/EYES/EARS/NOSE/THROAT			☐ **NA**
☐	☐	☐	Frequent or severe headaches
☐	☐	☐	Blurred vision/Double vision
☐	☐	☐	Corrective lenses or glasses
☐	☐	☐	Impaired hearing / Ringing in ears
☐	☐	☐	Chronic nasal congestion/discharge
☐	☐	☐	Recurring sinus infection
☐	☐	☐	Recurrent sore throat
☐	☐	☐	Other:
NEUROLOGICAL			☐ **NA**
☐	☐	☐	Fainting /Dizziness/ Blackouts
☐	☐	☐	Seizures/ Convulsions
☐	☐	☐	Memory loss
☐	☐	☐	Tremors/Shakiness
☐	☐	☐	Limb weakness/ numbness/tingling
☐	☐	☐	Other:
CARDIOVASCULAR			☐ **NA**
☐	☐	☐	Chest pain
☐	☐	☐	Heart fluttering/racing
☐	☐	☐	Shortness or breath
☐	☐	☐	Difficulty breathing when lying down
☐	☐	☐	Ankle swelling
☐	☐	☐	Other:
RESPIRATORY			☐ **NA**
☐	☐	☐	Shortness of breath
☐	☐	☐	Chronic cough
☐	☐	☐	Coughing up sputum
☐	☐	☐	Coughing up blood
☐	☐	☐	Asthma or wheezing
☐	☐	☐	Other:

NEVER	PAST	NOW	Have you ever had
GASTROINTESTINAL			☐ **NA**
☐	☐	☐	Frequent heartburns
☐	☐	☐	Nausea / vomiting
☐	☐	☐	Difficulty swallowing
☐	☐	☐	Abdominal pain
☐	☐	☐	Change of bowel habits (constipation or diarrhea)
☐	☐	☐	Blood in stool or rectal bleeding
☐	☐	☐	Hemorrhoids or rectal disease
☐	☐	☐	Other:
URINARY			☐ **NA**
☐	☐	☐	Frequent urination at night
☐	☐	☐	Frequent or painful urination
☐	☐	☐	Difficulty holding urine
☐	☐	☐	Difficulty stopping or starting urine stream
☐	☐	☐	Urinary tract infection
☐	☐	☐	Other:
GENITAL (MALE)			☐ **NA**
☐	☐	☐	Sores or discharges from penis
☐	☐	☐	Lump on or pain of testicles
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Decline in sexual desire
☐	☐	☐	Difficulty having erections or reaching climax
☐	☐	☐	Other:
GENITAL (FEMALE)			☐ **NA**
☐	☐	☐	Vaginal discharge or sores
☐	☐	☐	Vaginal wall weakness or protrusion
☐	☐	☐	Pain or troublesome symptoms before or during periods
☐	☐	☐	Painful intercourse
☐	☐	☐	Decline in sexual desire or difficulty in sexual response
☐	☐	☐	Hot flashes
☐	☐	☐	Change in periods (menstrual flow, frequency)
☐	☐	☐	No. of Pregnancies---------- No. of deliveries----------
☐	☐	☐	No. of miscarriages/abortions----------
☐	☐	☐	Age at onset of periods----------
☐	☐	☐	Onset of last period----------
☐	☐	☐	Other:

REVIEW OF SYSTEMS cont.

MUSCULOSKELETAL ☐ NA

☐ ☐ ☐ Limb or joint pains
☐ ☐ ☐ Limb or joint deformity
☐ ☐ ☐ Limb or joint swelling/stiffness/redness
☐ ☐ ☐ Muscle weakness
☐ ☐ ☐ Loss of muscle bulk
☐ ☐ ☐ Muscle spasms or twitching
☐ ☐ ☐ Recurring back/neck pain
☐ ☐ ☐ Back/neck injury
☐ ☐ ☐ Other:

HEMATOLOGIC/LYMPHATIC ☐ NA

☐ ☐ ☐ Anemia
☐ ☐ ☐ Blood clots
☐ ☐ ☐ Excessive bleeding/abnormal bruising
☐ ☐ ☐ Blood transfusion
☐ ☐ ☐ Unusual lymph node swelling (neck, arm pit, or groin)
☐ ☐ ☐ Painful lymph nodes
☐ ☐ ☐ Other:

ENDOCRINE ☐ NA

☐ ☐ ☐ Cold or heat intolerance
☐ ☐ ☐ Excessive thirst or hunger
☐ ☐ ☐ Other:

SKIN/BREAST ☐ NA

☐ ☐ ☐ Itching
☐ ☐ ☐ Rash
☐ ☐ ☐ Changes in hair
☐ ☐ ☐ Change or new growth in mole
☐ ☐ ☐ Breast Lump
☐ ☐ ☐ Breast Pain
☐ ☐ ☐ Nipple discharge
☐ ☐ ☐ Other:

PSYCHOLOGICAL ☐ NA

☐ ☐ ☐ Lapses in memory
☐ ☐ ☐ Periods of confusion/disorientation
☐ ☐ ☐ Difficulty concentrating
☐ ☐ ☐ Troublesome depression
☐ ☐ ☐ Mood swings
☐ ☐ ☐ Unusual stress
☐ ☐ ☐ Physical or mental abuse
☐ ☐ ☐ Other:

MISCELLANEOUS

☐ ☐ ☐ ----------
☐ ☐ ☐ ----------
☐ ☐ ☐ ----------

COMMENTS/EXPLANATIONS

PATIENT'S SIGNATURE _____ DATE_____

DOCTOR'S INITIALS_____