

PATIENT HEALTH QUESTIONNAIRE

PATIENT'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

What are you seeing the doctor for? \_\_\_\_\_  
Date of injury? \_\_\_\_\_ Did this injury happen while at work? { } yes { } no

Are you being treated for any other medical problems? { } yes { } no If yes – What?  
\_\_\_\_\_  
\_\_\_\_\_

Height? \_\_\_\_\_ Weight? \_\_\_\_\_

Are you { } right-handed, { } left-handed or { } ambidextrous

List any allergies to any medications:  
\_\_\_\_\_

List your current medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

yes no  
{ } { } Do you **smoke?** – If yes, how much?  
{ } { } Do you **drink alcohol?** – If yes, how much?  
{ } { } If **female** – Is there any possibility that you are **pregnant** at this time?

What kind of **operations** have you had? (When?) { } None  
1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have or have you had?  

<b>yes</b>	<b>no</b>		<b>yes</b>	<b>no</b>	<b>yes</b>	<b>no</b>		
{ }	{ }	Angina, Chest pain	{ }	{ }	Mitral valve prolapse	{ }	{ }	Thyroid disease
{ }	{ }	Heart "attack"	{ }	{ }	Severe headaches	{ }	{ }	Diabetes
{ }	{ }	Irregular heart beat	{ }	{ }	Asthma	{ }	{ }	Epilepsy, Stroke
{ }	{ }	High blood pressure	{ }	{ }	Hepatitis	{ }	{ }	Kidney disease
{ }	{ }	Heart disease	{ }	{ }	Bleeding disorder	{ }	{ }	Drug addiction
{ }	{ }	Cancer	{ }	{ }	Lung disease	{ }	{ }	Other _____

Does any member of your family have or have they ever had?  
{ } Arthritis                      { } Heart disease              { } Diabetes              { } Blood disorders  
{ } High blood pressure      { } Muscular disease          { } Cancer