

Patient Health Questionnaire

Patient Name: _____ Date: _____

Your Current Primary Care Doctor is: _____

List any other doctors that you would like to receive a copy of your medical notes

1. SINCE YOUR LAST VISIT: Have you had (please circle, if YES please describe)
Drs Comments

- | | | |
|--------|---|-------|
| YES NO | Chest Pain? _____ | _____ |
| YES NO | Shortness of Breath? _____ | _____ |
| YES NO | Palpitations? _____ | _____ |
| YES NO | Lightheadedness or Dizziness? _____ | _____ |
| YES NO | Blackouts? _____ | _____ |
| YES NO | Swelling in legs? _____ | _____ |
| YES NO | Weakness or Fatigue? _____ | _____ |
| YES NO | Do you smoke? _____ | _____ |
| YES NO | Are you exercising? _____ | _____ |
| YES NO | Do you ever experience pain or cramps in your
Calves or buttocks when walking? _____ | _____ |

2. SINCE YOUR LAST VISIT: Have you had (please circle, if YES please describe)
Drs. Comments

- | | | |
|--------|---|-------|
| YES NO | Recent weight loss or gain? _____ | _____ |
| YES NO | Fever or Chills, night sweats? _____ | _____ |
| YES NO | Easy bruising/bleeding? _____ | _____ |
| YES NO | New ulcers or sores? _____ | _____ |
| YES NO | Any problems with vision? _____ | _____ |
| YES NO | Any problems with Hearing? _____ | _____ |
| YES NO | Sore Throat? _____ | _____ |
| YES NO | Wheezing, Coughing? _____ | _____ |
| YES NO | Change in Bowel habits, abdominal pain _____ | _____ |
| YES NO | Problems with urination? _____ | _____ |
| YES NO | Problems with Kidneys? _____ | _____ |
| YES NO | Problems with sexual function? _____ | _____ |
| YES NO | Any symptoms of Stroke, weakness Numbness? | _____ |
| YES NO | Depression or psychiatric condition? _____ | _____ |
| YES NO | Have you had any change in occupational status? | _____ |
| YES NO | Have you been hospitalized, for what _____ | _____ |

3. Any new medical or surgical problems, or other new symptoms since your last visit:

Patient Name: _____ Date: _____

DOB: _____ AGE: _____ BP: _____

Weight: _____ HT: _____ BMI: _____

PCP: _____ CC: _____

Medications: _____

Allergies: _____

RISK FACTORS: DM HTN CHOL Smoking FH

Notes: _____

Physician Signature

Dictated