

Patient Health Questionnaire

Patient Name _____ Date _____

What type of regular exercise do you perform? None Light Moderate Strenuous

What is your height and weight? Height Feet Inches Weight lbs.

Please Check All That Apply

- | | | | | | |
|--------------------------|---|--------------------------|--|--------------------------|---|
| Past | Present | Past | Present | Past | Present |
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Smoking / Tobacco |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Angina | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> Dizziness |
| | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> Colon Problems | <input type="checkbox"/> | <input type="checkbox"/> Frequent Cold / Flu |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> Sinus Troubles |
| | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> Hip/Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Knee/Lower Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> Stroke |

Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy
- Menstrual Problems

Family History

- Heart Conditions _____
- Cancer _____
- Diabetes _____
- Other _____

Other Health Issues (surgeries, hospitalizations, etc)

List all the prescription or over-the-counter medications, and nutritional/herbal supplements you are taking:

HEALTH GOALS:

1. _____
2. _____
3. _____