Patient Health Questionnaire

Please complete all fields, save this file, and email it back to us — or print and bring it to your visit.

Patient Name

Date

REVIEW OF SYSTEMS — CHECK ANY YOU ARE CURRENTLY EXPERIENCING

Constitutional

☐ Fever ☐ Chills ☐ Fatigue ☐ Weight loss ☐ Weight gain

Cardiovascular

☐ Chest pain ☐ Palpitations ☐ Swelling in legs ☐ High blood pressure

Respiratory

☐ Shortness of breath ☐ Cough ☐ Wheezing

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Abdominal pain

Genitourinary

☐ Frequent urination ☐ Painful urination ☐ Blood in urine

Musculoskeletal

☐ Joint pain ☐ Muscle weakness ☐ Back pain ☐ Neck pain

Integumentary (Skin)

☐ Rash ☐ Itching ☐ Sores that do not heal

Neurological

☐ Headaches ☐ Numbness / tingling ☐ Dizziness ☐ Memory problems

Psychiatric

☐ Anxiety ☐ Depression ☐ Sleep problems ☐ Mood changes

Endocrine

☐ Diabetes symptoms ☐ Thyroid problems ☐ Heat/cold intolerance

Hematologic / Lymphatic

☐ Easy bruising ☐ Swollen glands

Allergic / Immunologic

☐ Seasonal allergies ☐ Frequent infections

FAMILY HEALTH HISTORY

Mother's health conditions

Father's health conditions

Patient Signature (type full name)

Date