Name: ____

Patient Health Questionnaire

Please mark all conditions which you currently have.

Constitutional Symptoms
- Fever
- Chills
- Fatigue

Nutritional Assessment
- Weight loss
- Weight gain
- Poor appetite

Cardiovascular
- High blood pressure
- Chest pain
- Heart attack
- Abnormal heart rhythm
- Swelling of ankles
- Pacemaker/ AICD
- Blood clot
- Use of blood thinners
- Mitral Valve Prolapse

Respiratory
- Painful breathing
- Productive cough
- Emphysema
- COPD
- TB
- Asthma

Gastrointestinal
- Abdominal pain
- Heartburn
- Hiatal hernia
- Ulcers
- Liver Problems
- Gallbladder problems
- Hepatitis
- Bloody Stools
- Diarrhea
- Constipation
- Loss of bowel control or incontinence

Genitourinary
- Painful urination
- Bladder infection
- Difficult urination
- Recent frequent urination
- Blood in urine
- Kidney Disease
- Kidney Failure
- STD
- Recent urinary retention
- Incontinence

Musculoskeletal
- Arthritis
- Swollen joints
- Muscle pain
- Fall or accident
- Major motor weakness

Integumentary (skin or breast)
- Rash
- Itching
- Bruise easily
- Shingles
- Skin cancer

Neurological
- Headache
- Multiple sclerosis
- Seizure
- Head injury
- Stroke
- Tremors
- Weakness
- Tingling
- Numbness
- Dizziness
- Loss of coordination

Psychiatric
- Alzheimer's
- Depression
- Anxiety
- Panic attacks
- Alcoholism
- Thoughts of suicide
- Irritability

Endocrine
- Thyroid disease
- Diabetes

Hematologic/ Lymphatic
- Leukemia
- Lymphoma
- Bleeding disorder
- Swollen glands
- Hepatitis

Immunologic
- AIDS
- HIV
- Cancer

Family Health History

Mother:

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Father:

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