PATIENT HEALTH QUESTIONNAIRE

NAME _____ **DATE** _____

DO YOU HAVE OR HAVE A HISTORY OF THE FOLLOWING:

	Y	N		Y	N		Y	N
Dry eyes	☐	☐	Fainting/black out(s)	☐	☐	Are you post menopausal?	☐	☐
Asthma/emphysema	☐	☐	Polio/paralysis	☐	☐	Are you or could you		
Shortness of breath	☐	☐	Back pain/injury	☐	☐	be pregnant?	☐	☐
High blood pressure	☐	☐	Numbness arms/legs	☐	☐	Would you agree to		
Chest pain	☐	☐	Anemia	☐	☐	a blood transfusion		
Irregular heart beats	☐	☐	Sickle Cell illness	☐	☐	in a life threatening		
Stroke(s)	☐	☐	Low blood sugar	☐	☐	case?	☐	☐
Seizure/epilepsy	☐	☐	Glaucoma/cataracts	☐	☐	Do you use Retin A?	☐	☐
Easy bleeding/bruising	☐	☐	Sleep apnea	☐	☐	Do you now or have you		
HIV	☐	☐	Cold sores/fever blisters			ever in the past		
Liver disease/hepatitis	☐	☐	Herpes simplex	☐	☐	taken Accutane?	☐	☐
Alcohol use	☐	☐	Heartburn/hiatal hernia			Do you take Aspirin		
Diabetes	☐	☐	Esophageal reflux	☐	☐	or Anticoagulants?	☐	☐
Thyroid disease	☐	☐	Cancer	☐	☐	Do you take Plavix?	☐	☐
Tuberculosis	☐	☐	Poor scarring/keloids	☐	☐			
Other lung issues	☐	☐	Do you smoke?	☐	☐			
Heart failure	☐	☐	Wear eyeglasses?	☐	☐	OTHER _____		
Heart attack(s)	☐	☐	Wear dentures?	☐	☐	_____		
Rheumatic fever	☐	☐	Wear hearing aids?	☐	☐	_____		
Heart murmur	☐	☐	Wear contact lenses?	☐	☐	_____		

List all previous surgeries:

_____

_____

List any allergies to drugs or medications:

_____

List all medications currently taking, including over-the-counter medications, herbs and vitamins:

_____

_____

COMMENTS:

_____

_____

_____