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Patient Health Questionnaire

Please fill out as much as possible to help with your medical care. Use the back of the sheet if you run out space. For medications, please include the dosage.

Date: ___________ **Patient Name:** ____

Date of Birth: _____/_____/_____ **Marital Status:** _________

Primary Doctor: ____

Referring provider: ____

****REASON FOR VISIT: **** _______________________________________

Past/Present Gastrointestinal Illnesses (Please circle)

Anemia	**Diverticulitis**	**Hepatitis B**
Cancer	**Diverticulosis**	**Hepatitis C**
Celiac	**Duodenal Ulcer**	**Irritable Bowel Syndrome**
Cirrhosis of the Liver	**Fatty Liver**	**Lactose Intolerance**
Colitis	**Gallstones**	**Pancreatitis**
Colon Cancer	**Gastric Cancer**	**Reflux**
Colon Polyps	**Gastric Polyp**	**Stomach Ulcer**
Chron's Disease	**H. Pylori**	**Ulcerative Colitis**
Depression	**Hepatitis A**	

Do you Smoke? Yes / No **If yes, how many packs per week? __________

Do you Drink Caffeine? Yes / No **If yes, how many drinks per week? ________

Do you Drink Alcohol? Yes / No **If yes, how many drinks per week? ________

Past Surgeries (Examples: Heart bypass, appendectomy etc)

Medication Allergies OR LATEX(please state drug and the reaction)

Medications (please include all medications including over the counter medicines. Include dosing information)

Medication name	**dose**	**frequency**

Are you on blood thinners? IE Coumidin, Lovenox, Aspirin, Plavix, or Other.

Do you have a history of endocarditis or artificial heart valve? **Yes / No**

Do you have a pacemaker? **Yes / No**
If yes, Cardiologist

Do you have a history of kidney problems? **Yes / No**

Do you have any other serious medical problems for which you currently being treated? **Yes / No**

Family History (any stomach, colon, liver disease or cancer)
Please Circle

Colitis	**Heart Trouble**
Colon Cancer	**Liver Cancer**
Colon Polyps	**Liver Disease**
Chron's Disease	**Pancreatic Cancer**
Esophageal Cancer	**Stomach Cancer**
Gall Bladder Disease	**Ulcer Disease**
OTHER__________	

Review of Systems: Please circle any symptoms that you currently have or have suffered from in the past.

General

Weight loss	Loss of appetite	Night Sweats
Fatigue/weakness	Fevers	

Gastrointestinal:

Heartburn	Rectal bleeding	Mucus in stool
Constipation	Painful defecation	Nausea
Diarrhea	Hepatitis	Hepatitis
Abdominal pain	Anal/rectal pain	Rectal Urgency
Abdominal cramps	Belching	Reflux
Ulcerative Colitis	Black stools	Soiling stool/Incontinence
Difficulty swallowing	Bloating	Vomiting
Hemorrhoids	Change in Bowel Habits	Weight Gain/Loss
Crohn's Disease	Flatulence/Gas	

Cardiovascular:

Chest pain	Irregular heart beat	Pain in legs with walking
Shortness of Breath	Swelling in legs	

Pulmonary:

Chronic cough	Shortness of breath	Coughing up blood
Wheezing	TB	Chronic Sore Throat

Skin:

Rash	Itching	Jaundice

Musculoskeletal:

Joint pains/swelling
Stiff joints
Back pain
Sciatica

Ears, Nose and Throat:

Hearing loss	Sores in mouth	Hoarse voice
Nose bleeds	Sore throat	Ringing in ears

Hematological:

Easy bruising	Bleeding problems

Psychiatric:

Abnormal sleep	Anxiety	Suicide Attempts
Depression	Bipolar disorder	

Neurological:

Headaches	Seizures	Extremity Weakness
Blurry Vision	Chronic numbness/tingling	Stroke or paralysis

Other symptoms:

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