Methodist Family Health Centers
PATIENT HEALTH QUESTIONNAIRE (pg 1/2)

Patient's name _____
Date of Birth _____

Gender M / F Marital Status S M W D Sep

Reason for visit _____

When was your last Tetanus Shot: _____ Have you had the flu shot this year? □ Yes □ No

Medical History (Mark all that apply)

Childhood Illnesses	□ Rheumatic fever	□ Mumps	□ Scarlet fever	□ Chicken pox	□ Polio	□ Measles
Patient History	□ Diabetes Mellitus	□ Asthma	□ Hypertension	□ Heart Disease	□ Glaucoma	□ Migraine
□ Ulcers	□ High Cholesterol	□ Stroke	□Tuberculosis	□ Kidney Disease	□ Cancer	□ Depression
□ Arthritis	□ Thyroid Disease	□ Anemia	□ Osteoporosis	□ Alcoholism	□ Seizures	□ Mental Illness
□ Hepatitis		□ Other (please list)				

Drug Allergies: _____

Current Medications (including non-prescription medications and supplements): _____

_____

_____

_____

Last doctor's visit _____ **Doctor's name** _____

Hospitalizations _____

_____

Surgeries _____

_____

Social History

Occupation _____ Hours/week: _____ Satisfied with job: _____
Alcohol _____ drinks per week Coffee / Tea _____ cups/day
Tobacco: Smoking _____ cigarettes/day # Years: _____ Year quit: _____
Chewing _____ cans/week # Years: _____ Year quit: _____
Recreational drugs _____ Last used: _____
Do you follow a particular diet? (explain) _____
Do you exercise regularly? _____

Family History: (If any relative has suffered any of the following, mark and indicate which relative)
F – Father M – Mother S – Sibling C – Child R – Other Relative

□ Diabetes F M S C R	□ Thyroid Disease F M S C R	□ Alcoholism F M S C R
□ Hypertension F M S C R	□ Heart Disease F M S C R	□ Arthritis F M S C R
□ Asthma F M S C R	□ High Cholesterol F M S C R	□ Seizures F M S C R
□ Anemia F M S C R	□ Osteoporosis F M S C R	□ Glaucoma F M S C R
□ Stroke F M S C R	□ Migraine F M S C R	□ Cancer F M S C R

Chart # _____ Reviewed by _____ Date _____

Methodist Family Health Centers **Patient's name** _____

PATIENT HEALTH QUESTIONNAIRE (pg 2/2) **Date of Birth** _____

Systems Review: Check any of the following which you have had in the last 3 months

General	**Breast**	**Cardiac**	**Neurologic**
□ Fever or chills	□ Tenderness	□ Chest pain	□ Headache
□ Fatigue	□ Discharge	□ Swollen ankles	□ Dizziness
		□ Irregular pulse	□ Seizures
Nutritional	**Respiratory**	□ Leg pain when walking	□ Numbness or tingling
□ Weight loss	□ Cough	□ Heart murmur	□ Tremor
	□ Shortness of breath	□ Varicose veins	□ Muscle weakness
Skin	□ Asthma / wheezing	□ Phlebitis	□ Passing out
□ Rash / hives	□ Pneumonia		
□ Psoriasis / Eczema	□ Bronchitis		**Endocrine**
□ New moles		**Urinary**	□ Heat or cold intolerance
	Gastrointestinal	□ Painful urination	□ Thirst
Eyes	□ Heartburn	□ Loss of urinary control	□ Frequent urination
□ Eye irritation and itching	□ Nausea / vomiting	□ Frequent urination	
□ Eye pain	□ Loss of appetite	□ Urination>2x nightly	
□ Eye infections	□ Difficulty swallowing	□ Decreased force or flow	**Psychiatric**
□ Vision changes	□ Abdominal pain (chronic)	□ Blood in urine	□ Sleeping difficulty
	□ Change in bowel habits	□ Kidney stones	□ Depression
Ears	□ Constipation	□ Urine infections	□ Nervousness
□ Ear pain	□ Diarrhea		□ Memory loss
□ Popping – pressure	□ Bloody or Tarry stools	**Genital**	□ Moodiness
□ Ringing in ears	□ Gallbladder trouble	□ Irritation/Infection	□ Mental illness
□ Ear infections (frequent)	□ Jaundice	□ Discharge	□ Phobias
□ Hearing loss	□ Hepatitis	□ Sexual difficulties	
□ Dizziness	□ Diverticulosis		**Hematology**
	□ Colitis	**Musculoskeletal**	□ Bruising
Nose	□ Hemorrhoids	□ Joint pain	□ Bleeding
□ Sinus trouble	□ Hernia	□ Back pain	□ Blood transfusions (lifetime)
□ Runny nose		□ Bone fracture	□ Enlarged lymph nodes
		□ Joint injury	
Throat		□ Gout	**Allergies / Immune**
□ Sore throat		□ Foot pain	□ Seasonal allergies
□ Hoarseness		□ Cold / numb feet	□ Frequent illnesses

FEMALES		**MALES**
Menstrual Flow		Prostate exam date
□ Regular Days of flow Length of cycles		PSA Test date
□ Irregular □ Pain / bleeding during or after sex		
□ Pain / cramps		**MALE & FEMALE**
Obstetric history		Have you had a colonoscopy? □ **Yes** □ **No Date:**
Number of pregnancies Number of children		Results: □ Normal □ Polyps □ Other
Birth control method Miscarriages		
Birth control pill name		
Menopause symptoms		
Flushing		
Health Maintenance		
Date of last Pap smear normal / abnormal		
Date of last mammogram normal / abnormal		

Chart # _____ Reviewed by _____ Date _____