PATIENT HEALTH QUESTIONNAIRE

Name ______________________________ Age ___________________ Date _________________

What are you seeing the doctor for? ____

Date of injury ___________________________ Is your general health good? ☐ Yes ☐ No

Please list any (all) operations you have had in the past: Date: Complications:

1. ____

2. ____

3. ____

4. ____

Do you have, or have you ever had: ☐

Yes	No		Yes	No		Yes	No	
		Heart Disease			Lung Disease, TB			Diabetes
		Angina, chest pain			Emphysema			Glaucoma
		Heart Attack			Asthma			Epilepsy, stroke
		Irregular heart beat			Wheezing			Mental Illness
		High blood pressure			Hepatitis, jaundice			Drug Addiction
		Mitral valve prolapsed			Bleeding Tendency			Kidney disease
		Severe headaches			Thyroid disease			Sleep Apnea
Other:								

Yes	No					
		Do you have:	Caps? ☐	Loose or chipped teeth? ☐	Bridges? ☐	Dentures? ☐
		Do you wear:	Contact Lenses? ☐	Hearing aid? ☐	False eye? ☐	
		Do you have difficulty opening your mouth or moving your neck?				
		Do you presently have a cold or the flu?				
		Do you drink alcohol? If so how much?				
		Do you smoke? If so, how much?				
		Females: Is there any possibility that you are pregnant at this time?				

List any allergies: ____

List all current medications: ____

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_________________________________ _________________________________

Patient Signature Date