Douglas J. Abeles M.D. & Associates
21030 Redwood Road.
Castro Valley Ca 94546
P. (510) 538-0430 F. (510) 538-1839

Douglas J. Abeles M.D. *Marc A. Munoz P.A-C*

Patient Health Questionnaire

Instructions: Please print & answer all the questions to the best of your ability. Date: ____/ ____/____

Patient Name: _____

Height: _____ Weight: _____

Age: _____ Pulse-B/P: _____

ALLERGIES/DRUG REACTIONS: Please list all allergies

Any allergy to metals: _____

Chief Complaint Today: _____

History of Present Illness:
Date this problem/injury began: _____
(Note: If you do not give a date, your insurance carrier will not pay and you will be expected to pay before you leave today)

Medications: List all medications you regularly take now.

Drug Name	Dosage	Amount Per Day

Surgeries: (For example, orthopedic, gastric bypass, heart)

Year	Illness/Operations	Name of Hospital

Past Medical History: Have you ever had the following:

Diabetes	•Y	•N	Cancer	•Y	•N
High Blood Pressure	•Y	•N	what kind_____		
Heart Attack	•Y	•N	COPD	•Y	•N
Heart Failure	•Y	•N	Asthma	•Y	•N
Other Heart Disease	•Y	•N	Sleep Apnea	•Y	•N
(ex. coronary artery disease, valve disease, arrhythmia)			Thyroid Disease	•Y	•N
			Organ Transplant	•Y	•N
Blood Clot	•Y	•N	Ulcers/Reflux Disease	•Y	•N
Pulmonary Embolism	•Y	•N	Kidney Disease	•Y	•N
Stroke	•Y	•N	Bladder Infections	•Y	•N
Bleeding Disorder	•Y	•N	Neuropathy	•Y	•N
High Cholesterol	•Y	•N	Liver Disease	•Y	•N
Vascular Disease	•Y	•N	Lymphedema	•Y	•N
Rheumatoid Arthritis	•Y	•N	Psychiatric Disorder	•Y	•N
Lupus	•Y	•N	Other_____		
Gout	•Y	•N			

Family History: Has any blood relative had any of the following:

Cancer	•Y	•N	Relationship: _____
Diabetes	•Y	•N	_____
Heart Disease	•Y	•N	_____
Stroke	•Y	•N	_____
High Blood Pressure	•Y	•N	_____
Kidney Disease	•Y	•N	_____
Liver Disease	•Y	•N	_____
Osteoporosis	•Y	•N	_____

OTHER: _____

Social History: Do you consume any of the following:

Tobacco	•Y	•N	Packs Per Day: _____ Years: _____
Alcohol	•Y	•N	Drinks Per Week:_____ Years:_____
Caffeine	•Y	•N	Cups Per Day: _____ Years: _____
Illegal Drugs	•Y	•N	Type: _____ Years: _____

Left or Right Handed_____
Occupation_____
How many stairs at home_____
Who lives at home with you_____
Use any assistive devices (cane, walker) _____

Review of Systems

Please mark yes or no to the following symptoms.
If you are not sure, leave blank.

Musculoskeletal			**Site of problem R/L**
•Y	•N	Painful joints	
•Y	•N	Swelling of any joints	
•Y	•N	Redness of any joints	
•Y	•N	Stiffness of any joints	
•Y	•N	Deformities joints or extremities	
•Y	•N	Muscle pain	
•Y	•N	Back pain	
•Y	•N	Pain down the back of your legs	

Injuries: List all significant injuries that you can recall either in childhood or adult life with an approximate date and complications.

Injury	Year	Complications/Comments

GENERAL

•Y •N Weakness
•Y •N Weight Loss
•Y •N Chills
•Y •N Night Sweats
•Y •N Tiredness
•Y •N Early morning
•Y •N Late afternoon

•Y •N Excessive Appetite
•Y •N Weight Gain
•Y •N Fever
•Y •N Lack of Appetite

Patient Health Questionnaire- Page 2

EYES, EARS, NOSE & THROAT

•Y •N Decreased ability to see
•Y •N Spots before your eyes
•Y •N Infection in eyes
•Y •N Ringing in ears
•Y •N Nosebleeds
•Y •N Sneezing
•Y •N Sinus trouble
•Y •N Sore throat
•Y •N Pain in neck
•Y •N Bleeding gums

•Y •N Blurred Vision
•Y •N Pain in eyes
•Y •N Difficulty in hearing
•Y •N Pain in your ears
•Y •N Stuffy Nose
•Y •N Post-Nasal drip
•Y •N Hay fever
•Y •N Hoarseness
•Y •N Dental trouble

RESPIRATORY

•Y •N Dry cough
•Y •N Cough up phlegm
•Y •N Cough up blood
•Y •N Wheezing
•Y •N Asthma
•Y •N Shortness of breath at rest
•Y •N Shortness of breath at exertion
•Y •N Chest pain when cough, sneeze or move

CARDIOVASCULAR

•Y •N Chest pain, tightness or squeezing
•Y •N Shortness of breath lying down
•Y •N Need to sit up and breath
•Y •N Heart racing
•Y •N Irregular heart beat (palpitations)
•Y •N Heart murmur
•Y •N Varicose veins
•Y •N Leg pain at rest
•Y •N Leg pain with exertion
•Y •N Blue/Purple discoloration of hands or feet

GASTROINTESTINAL

•Y •N Nausea
•Y •N Vomiting
•Y •N Diarrhea
•Y •N Constipation
•Y •N Heartburn
•Y •N Abdominal pain

•Y •N Bright red blood in stool
•Y •N Black stool
•Y •N Change in bowel habits
•Y •N Food intolerance
•Y •N Need for antacids
•Y •N Hemorrhoids

URINARY

•Y •N Urinary tract Infections
•Y •N Pain or burning
•Y •N Frequent urination-Day
•Y •N Frequent urination-Night
•Y •N Unusually large volumes of urine
•Y •N Extreme urges to urinate
•Y •N Difficulty starting urinary stream
•Y •N Difficulty stopping urinary stream
•Y •N Kidney Stones

REPRODUCTIVE-FEMALE

•Y •N Sexually transmitted disease(s)-please list
•Y •N When was the last date of your period
•Y •N Are you bothered with hot flashes?
•Y •N Are you pregnant?

REPRODUCTIVE-MALE

•Y •N Sexually transmitted disease(s)-please list
•Y •N Testicular pain
•Y •N Lumps in testicles or scrotum
•Y •N Decrease in testicular size

ENDOCRINE

•Y •N Goiter
•Y •N Heat intolerance
•Y •N Cold intolerance
•Y •N Tremulousness of the hands
•Y •N Change in pitch of the voice
•Y •N Increased body hair (face, arms, pubic)
•Y •N Decreased body hair
•Y •N Decreased in breast size
•Y •N Loss of periods (disregard if menopausal)
•Y •N Increased thirst
•Y •N Increased urinations
•Y •N Marked increase in appetite

NEUOLOGIC / PSYCHIATRIC

•Y •N Nervousness
•Y •N Depression
•Y •N Difficulty going to sleep
•Y •N Early morning awakening
•Y •N Difficulty w/ memory for past events
•Y •N Difficulty w/ memory for recent events
•Y •N Difficulty w/ thinking or problem solving
•Y •N Headaches
•Y •N Blackouts
•Y •N Dizziness
•Y •N Double Vision
•Y •N Paralysis or weakness of a limb(s)
•Y •N Loss of sensation
•Y •N Loss of balance
•Y •N Loss of coordination
•Y •N Difficulty in speaking

SKIN

•Y •N Dryness of skin
•Y •N Rash
•Y •N Nail changes
•Y •N Change in texture of hair

•Y •N Itching
•Y •N Skin color change
•Y •N Skin ulcers
•Y •N Hair falling out

Physician/Comments: _____

____

Physician Signature: ____________________Date: ________