EXISTING PATIENT HEALTH QUESTIONNAIRE

Name ____ Age _________ Date ________________

Reason for your visit today: ____

MEDICATIONS/ ALLERGIES

Current medications (prescription and over-the-counter) ____

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Vitamin, herbal, or calcium supplements ____

Medication Allergies (with reaction) ____

Any known allergy to LATEX? …………………………………………………………… Yes No

REPRODUCTIVE HISTORY

First day of last menstrual period _________________ Date of last Pap smear __________________

Current contraceptive method _____________________ Last mammogram ______________________

MEDICAL/ SURGICAL HISTORY – **Any changes since your last annual?**

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FAMILY HISTORY – **Any significant new diagnoses in the last year (parents, grandparents, siblings, children)?**

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PERSONAL HISTORY

What major stressors are currently affecting you?____

Are you coping well with them? ……………………………………………………………. Yes No

Do you often feel sad or miserable? ………………………………………………………... Yes No

Do you often have any difficulty sleeping? ……………………………………………… Yes No

Are you having trouble enjoying/ participating in daily activities? ……………………… Yes No

Do you ever think of harming yourself or others? ……………………………………….. Yes No

ANY OTHER ISSUES/ CONCERNS: ____

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