

If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

PATIENT HEALTH QUESTIONNAIRE

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain (723.1)
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (719.41)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (719.42)
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (719.44)
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (719.43)
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain (724.1)
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain (724.2)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (719.45)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (729.5)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (719.47)
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain (526.9)
<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Stiffness of Joint(s)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting (780.2)
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances (368.9)
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions (780.3)
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness (780.4)
<input type="checkbox"/>	<input type="checkbox"/>	Headache (784.0)
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination (781.3)
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises) (388.30)
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat (785.0)
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains (786.50)
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite (783.0)
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia (307.1)
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain (783.1) <input type="checkbox"/> Loss (783.2)
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst (783.5)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough (786.2)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis (473.9)
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue (780.7)
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow (626.4)
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow (626.7)
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps (611.72)
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis (617.9)
<input type="checkbox"/>	<input type="checkbox"/>	PMS (625.4)
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control (788.30)
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination (788.1)
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination (788.41)
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain (789.0)
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits (564.0)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing (787.2)
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion (787.1)
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash (692.9)
<input type="checkbox"/>	<input type="checkbox"/>	Depression (311)

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm (441.5)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure (401.9)
<input type="checkbox"/>	<input type="checkbox"/>	Angina (413.9)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (410.9)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (436)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (493.9)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (199.1)
<input type="checkbox"/>	<input type="checkbox"/>	Tumor (229.9)
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems (601.9)
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder (790.6)
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders) (492.8)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (716.9)
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis (714.0)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (250.0)
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (349.5)
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer (556.9)
<input type="checkbox"/>	<input type="checkbox"/>	Liver (573.9) / Gallbladder (575.9) problems
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones (592.0)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (573.3)
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection (595.9)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Colitis (558.9)
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon (564.1)
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS (042)
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

If a family member has had any of the following please mark the appropriate box:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other Conditions _____
<input type="checkbox"/> High Blood Pressure	

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a permanent disability rating?
<input type="checkbox"/>	<input type="checkbox"/>	Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Date rating received ____/____/____
		Rating Percentage _____%

Please check any of the following that apply to you.

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy (V22.2)
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Hormonal/Estrogen Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere)

<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization/Surgical Procedures (list if not described elsewhere)

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco (305.1)
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol (305.0)
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence (303.9)
<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft drinks:
		cups/cans per day _____

Present: Weight _____ pounds Height ____ feet ____ inches

Patient's signature: _____ Date: ____/____/____

Doctor's Additional Comments/General Health Concerns:
