UTHealth
East Texas Physicians

Print Name of Patient: _____ _____ DOB

Patient Health Questionnaire

This questionnaire is intended to establish a number of basic health facts which are important to the analysis of your problem(s) and to gain a comprehensive picture of your health. It is not intended to substitute for a personal interview, but rather to ensure that as much time as possible will be spent discussing the problems that concern you.

CHIEF COMPLAINT: (Briefly describe your main reason(s) for coming to the doctor today.) _____

_____

_____

Other Medical Problems: _____

_____

_____

Childhood Illnesses: _____

Previous Surgeries: (include dates) _____

_____

_____

_____

_____

SOCIAL HISTORY:

A. Habits:

Do you smoke? ☐ Y ☐ N How much? _____ How long? _____

Do you drink alcoholic beverages? ☐ Y ☐ N How often / long? _____

Do you drink coffee/tea? ☐ Y ☐ N How much? _____

Do you follow a particular diet? ☐ Y ☐ N If so, for what reason? _____

Do you exercise regularly? ☐ Y ☐ N What Kind? _____ How often/long? _____

B. Occupation:

What kind of work do you do? _____

How long? _____ Hours/Week? _____ Are you satisfied? ☐ Y ☐ N

Are you aware of any hazardous exposures or other health problems associated with your present or past employment? ☐ Y ☐ N If yes, what? _____

Have you changed jobs for health reasons? ☐ Y ☐ N Served in the Military? ☐ Y ☐ N

Have you received Workers' Comp. or other disability? ☐ Y ☐ N

C. Personal:

Highest level of education: ☐ High School ☐ College ☐ Technical / Business

Hobbies you enjoy: _____

Where were you born? _____ Where else have you lived? _____

FAMILY HISTORY: *(Please list any family member with major health problem(s) and specify the problem(s)*

☐ Father: _____

☐ Mother: _____

☐ Brothers / Sisters: _____

MEDICATION:

Allergies: _____ **Reaction:** _____

_____ _____

_____ _____

_____ _____

Current Meds / Reason: _____

_____

_____

_____

Date(s) of last immunization(s): _____

RECENT DIAGNOSTIC STUDIES: *(Please give date)*

X-Ray (specify type): _____
_____
_____
_____
_____

EKG _____
PAP Smear _____
Mammogram _____
Pulmonary Functions _____
GI Series _____
Proctoscopy/Colonoscopy _____
Dental Work _____

REVIEW OF SYSTEMS: *(Please check any of the problems below that you have now or have had recently.*

- ☐ Ear / Hearing trouble
- ☐ Visual / Eye difficulties
- ☐ Nasal / Sinus trouble
- ☐ Teeth / Gum problems
- ☐ Persistent hoarseness
- ☐ Coughing up blood
- ☐ Difficulty swallowing
- ☐ Frequent, severe cough
- ☐ Pain or lumps in neck
- ☐ Chest Pain / Tightness
- ☐ Racing heartbeat
- ☐ Shortness of breath
- ☐ Stomach pain
- ☐ Nausea, vomiting
- ☐ Heartburn, gas, belching, bloating
- ☐ Poor or excessive appetite
- ☐ Marked weight change
- ☐ Constipation / Diarrhea
- ☐ Rectal pain, bleeding, itch
- ☐ Painful or frequent urination
- ☐ Blood in urine
- ☐ Vaginal discharge / Menstrual problems
- ☐ Breast pain or lumps
- ☐ Take birth control pills
- ☐ Joint pain, swelling, stiffness
- ☐ Muscle pain, weakness
- ☐ Feet / Ankle swelling
- ☐ Blackout spells
- ☐ Dizziness
- ☐ Frequent or severe headache
- ☐ Difficulty sleeping
- ☐ Depression, crying spells
- ☐ Excessive worry
- ☐ Frightening thoughts / dreams
- ☐ Loss of memory or concentration
- ☐ Work or family problems
- ☐ Desire psychiatric help
- ☐ Fever or chills
- ☐ Painful testicles
- ☐ Sexual problems
- ☐ Skin problems, change in mole
- ☐ Severe, persistent itching
- ☐ Numbness, tingling
- ☐ Severe fatigue
- ☐ Trembling, shaking
- ☐ Use marijuana or hard drugs