Patient Health Questionnaire

Name: ______________________________ Date: ______________

General

Fever	O Yes	O No
Weight loss	O Yes	O No

Musculoskeletal

joint pain	O Yes	O No
joint stiffness	O Yes	O No
joint swelling	O Yes	O No
muscle pain	O Yes	O No

Ophthalmology

dry eyes	O Yes	O No
red eyes	O Yes	O No

ENT

nose bleed	O Yes	O No
dry mouth	O Yes	O No
sores in mouth	O Yes	O No
nasal discharge	O Yes	O No

Respiratory

cough	O Yes	O No
chest pain	O Yes	O No

Cardiology

leg swelling	O Yes	O No
shortness of breath	O Yes	O No

Gastroenterology

difficulty swallowing	O Yes	O No
heartburn	O Yes	O No
blood in stool	O Yes	O No

Dermatology

rash	O Yes	O No
Blue finger or toe	O Yes	O No
hair loss	O Yes	O No
Rash with sun exposure	O Yes	O No
nodule	O Yes	O No

Neurology

headache	O Yes	O No
difficult to get up from chair	O Yes	O No

Genitourinary

blood in urine	O Yes	O No
genital ulcer	O Yes	O No

Hematology/Lymph

swollen glands	O Yes	O No
night sweats	O Yes	O No