Patient Health Questionnaire

Name:_____ DOB:_____ Date:_____

Age: _____ Height: _____ Weight: _____ Reason for Visit: _____

Medications

Please list your medications with dosages (include all prescription, non-prescription and herbal medications)

_____

_____

_____

_____

_____

_____

_____

_____

Allergies/Reaction

Please list any allergy including those to drugs, latex, adhesive tape, food, etc. and include your reaction

_____

_____

_____

_____

Past Surgical History:

Please list the date and type of any surgeries

_____

_____

_____

_____

_____

Have you or anyone in your family ever had a problem with anesthesia? If so, please explain

_____

__

Social History

Current Smoker: Yes / No

Packs per day_____ # of years

_____

Former Smoker: Yes / No

Year Quit

_____

Alcohol Use: Yes / No

Frequency

_____

Recreational Drug Use: Yes / No

Type/Frequency

_____

Occupation:

_____

Family History (Relation):

Heart Disease:

_____

Stroke:_____

__

Varicose Veins:_____

Cancer/ Type:_____

High Blood
Pressure:________________________

Diabetes:________________________________
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