PATIENT HEALTH SURVEY (Page 1 of 2)

Patient Name: (LAST, FIRST, MIDDLE) ______ Date: ______

Please indicate in your own words the reason for your visit today:

Explain:

Check **YES** if you are experiencing any of the symptoms or conditions below:

GENERAL	Y?	**RESPIRATORY**	Y?	**ENDOCRINE**	Y?
Fevers		Cough		Thyroid Problems	
Chills		Dyspnea (difficulty breathing)		**ALLERGIC / IMMUNOLOGIC**	
Sweats		Excessive Sputum		Hay Fever	
Loss of Appetite		Hemoptysis (coughing blood)		Allergies	
Fatigue		Wheezing		HIV Positive	
Weight Change		**CARDIO**		**MUSCOLOSKELETAL**	
EYES		Chest Pain		Back Pain or Neck Pain	
Blurring		Difficulty Breathing During Exercise		Joint Pain	
Diplopia (double Vision)		Heart Condition		Joint Swelling	
Irritation		Palpitations		TMJ	
Discharge		Syncope (loss of consciousness)		**SKIN**	
Vision Loss		Peripheral Edema (swelling)		Rash	
Increased Sensitivity to Light		**GASTROINTESTINAL**		Itching	
EARS/NOSE/THROAT		Nausea		Suspicious Lesion/Mole	
Earache		Vomiting		**NEUROLOGIC**	
Ear Discharge		Heartburn		Weakness	
Tinnitus (ringing in ears)		Diarrhea		Syncope (fainting)	
Decrease in Hearing		Acid Reflux		Tremors	
Sinus Trouble		Abdominal Pain		Vertigo (dizziness)	
Nasal Congestion		**GENITOURINARY**		**PSYCHIATRIC**	
Nose Bleeds		Incontinence		Depression	
Snoring		Dysuria (pain during urination)		Anxiety	
Facial Pain / Pressure		Urinary frequency / Urgency		Memory Loss	
Sore Throat		**HEMATOLOGIC/LYMPHATIC**		Mental Disturbance	
Hoarseness		Abnormal Bruising			
Dysphagia (trouble swallowing)		Bleeding			
		Enlarged Glands			

DRUG ALLERGIES (note reactions/side-effect)	**ENVIROMENTAL ALLERGIES**
☐ No Known Drug Allergies	☐ No Known Allergies

MEDICATIONS (with dose and frequency)

PHARMACY NAME, NUMBER, LOCATION

PAST MEDICAL HISTORY: Have you had or do you have any of the following								
Transfusion	☐ YES	☐ NO	Stroke	☐ YES	☐ NO	Fibromyalgia	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO	Abnormal bleeding	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Migraines / Headaches	☐ YES	☐ NO	Anemia	☐ YES	☐ NO
COPD/Emphysema	☐ YES	☐ NO	Kidney Infection	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO	Kidney Stones	☐ YES	☐ NO	Ulcer, gastritis, reflux	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO	Bladder Infection	☐ YES	☐ NO	Weight Loss	☐ YES	☐ NO
Congestive Heart Failure	☐ YES	☐ NO	Venereal Disease	☐ YES	☐ NO	Fits/ Convulsions	☐ YES	☐ NO
Atrial Fibrillation	☐ YES	☐ NO	Prolonged Antibiotics	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Hypertension	☐ YES	☐ NO	Sinusitis	☐ YES	☐ NO	Tumor*	☐ YES	☐ NO
Hypercholesterolemia	☐ YES	☐ NO	Thyroid Disorder	☐ YES	☐ NO	Cancer*	☐ YES	☐ NO
Injury to ear, nose, throat	☐ YES	☐ NO	Arthritis	☐ YES	☐ NO	HIV	☐ YES	☐ NO
Specify site and treatment for cancer, tumor or growth:								

HISTORY OF OPERATIONS:

1.	Year:
2.	Year:
3.	Year:
4.	Year:
5.	Year:
6.	Year:

FAMILY HISTORY (note relationship)

Heart Attack	☐ Y	☐ N	______	Hypertension	☐ Y	☐ N	______
Cancer (w/type)	☐ Y	☐ N	______	Allergies	☐ Y	☐ N	______
Stroke	☐ Y	☐ N	______	Diabetes	☐ Y	☐ N	______
Asthma	☐ Y	☐ N	______	Hearing Loss	☐ Y	☐ N	______
Immunodeficiency	☐ Y	☐ N	______	Sinus Disease	☐ Y	☐ N	______
Bleeding Disorder	☐ Y	☐ N	______	Other	☐ Y	☐ N	______

SOCIAL HISTORY: Have you ever smoked or chewed tobacco? ☐ **YES** ☐ **NO** How Long? ______

If you currently smoke…… How Long? ______ How much ______ Packs per day.

If you quit….. Year you quit: ______

Do you drink alcoholic beverages? ☐ **YES** ☐ **NO** How often? ______

Do you or have you ever used drugs? ☐ **YES** ☐ **NO** Please list: ______

SOURCE OF INFORMATION IF OTHER THAN PATIENT:

______ **DATE:** ______

SIGNATURE OF PERSON OR PATIENT ACQUIRING INFORMATION:

______ **DATE:** ______