Methodist Family Health Centers
PATIENT HEALTH QUESTIONNAIRE (pg 1/2)

Patient's name ____________________
Date of Birth ____________________

Gender M / F Marital Status S M W D Sep

Reason for visit____________________

When was your last Tetanus Shot: ____________ Have you had the flu shot this year? ☐ Yes ☐ No

Medical History (Mark all that apply)

Childhood Illnesses	☐ Rheumatic fever	☐ Mumps	☐ Scarlet fever	☐ Chicken pox	☐ Polio	☐ Measles
Patient History	☐ Diabetes Mellitus	☐ Asthma	☐ Hypertension	☐ Heart Disease	☐ Glaucoma	☐ Migraine
☐ Ulcers	☐ High Cholesterol	☐ Stroke	☐Tuberculosis	☐ Kidney Disease	☐ Cancer	☐ Depression
☐ Arthritis	☐ Thyroid Disease	☐ Anemia	☐ Osteoporosis	☐ Alcoholism	☐ Seizures	☐ Mental Illness
☐ Hepatitis		☐ Other (please list)				

Drug Allergies:____________________

Current Medications (including non-prescription medications and supplements):____________________

____

____

____

Last doctor's visit ____________________ **Doctor's name** ____________________

Hospitalizations____________________

____

Surgeries ____________________

____

Social History

Occupation____________________ Hours/week:__________ Satisfied with job:__________

Alcohol__________drinks per week Coffee / Tea __________ cups/day

Tobacco: Smoking __________cigarettes/day # Years:__________ Year quit:__________

Chewing__________ cans/week # Years:__________ Year quit:__________

Recreational drugs ____________________ Last used: __________

Do you follow a particular diet? (explain)____________________

Do you exercise regularly? ____________________

Family History: (If any relative has suffered any of the following, mark and indicate which relative)

F – Father M – Mother S – Sibling C – Child R – Other Relative

☐ Diabetes F M S C R	☐ Thyroid Disease F M S C R	☐ Alcoholism F M S C R
☐ Hypertension F M S C R	☐ Heart Disease F M S C R	☐ Arthritis F M S C R
☐ Asthma F M S C R	☐ High Cholesterol F M S C R	☐ Seizures F M S C R
☐ Anemia F M S C R	☐ Osteoporosis F M S C R	☐ Glaucoma F M S C R
☐ Stroke F M S C R	☐ Migraine F M S C R	☐ Cancer F M S C R

Chart # __________ Reviewed by ____________________ Date __________

Methodist Family Health Centers **Patient's name** ___________________________________

PATIENT HEALTH QUESTIONNAIRE (pg 2/2) **Date of Birth** ______________________________________

Systems Review: Check any of the following which you have had in the last 3 months

General	**Breast**	**Cardiac**	**Neurologic**
□ Fever or chills	□ Tenderness	□ Chest pain	□ Headache
□ Fatigue	□ Discharge	□ Swollen ankles	□ Dizziness
		□ Irregular pulse	□ Seizures
Nutritional	**Respiratory**	□ Leg pain when walking	□ Numbness or tingling
□ Weight loss	□ Cough	□ Heart murmur	□ Tremor
	□ Shortness of breath	□ Varicose veins	□ Muscle weakness
Skin	□ Asthma / wheezing	□ Phlebitis	□ Passing out
□ Rash / hives	□ Pneumonia		
□ Psoriasis / Eczema	□ Bronchitis		**Endocrine**
□ New moles		**Urinary**	□ Heat or cold intolerance
	Gastrointestinal	□ Painful urination	□ Thirst
Eyes	□ Heartburn	□ Loss of urinary control	□ Frequent urination
□ Eye irritation and itching	□ Nausea / vomiting	□ Frequent urination	
□ Eye pain	□ Loss of appetite	□ Urination>2x nightly	
□ Eye infections	□ Difficulty swallowing	□ Decreased force or flow	**Psychiatric**
□ Vision changes	□ Abdominal pain (chronic)	□ Blood in urine	□ Sleeping difficulty
	□ Change in bowel habits	□ Kidney stones	□ Depression
Ears	□ Constipation	□ Urine infections	□ Nervousness
□ Ear pain	□ Diarrhea		□ Memory loss
□ Popping – pressure	□ Bloody or Tarry stools	**Genital**	□ Moodiness
□ Ringing in ears	□ Gallbladder trouble	□ Irritation/Infection	□ Mental illness
□ Ear infections (frequent)	□ Jaundice	□ Discharge	□ Phobias
□ Hearing loss	□ Hepatitis	□ Sexual difficulties	
□ Dizziness	□ Diverticulosis		**Hematology**
	□ Colitis	**Musculoskeletal**	□ Bruising
Nose	□ Hemorrhoids	□ Joint pain	□ Bleeding
□ Sinus trouble	□ Hernia	□ Back pain	□ Blood transfusions (lifetime)
□ Runny nose		□ Bone fracture	□ Enlarged lymph nodes
		□ Joint injury	
Throat		□ Gout	**Allergies / Immune**
□ Sore throat		□ Foot pain	□ Seasonal allergies
□ Hoarseness		□ Cold / numb feet	□ Frequent illnesses

FEMALES			**MALES**
Menstrual Flow			Prostate exam date
□ Regular	Days of flow	Length of cycles	PSA Test date
□ Irregular	□ Pain / bleeding during or after sex		
□ Pain / cramps			**MALE & FEMALE**
Obstetric history			Have you had a colonoscopy? □ **Yes** □ **No Date:**
Number of pregnancies	Number of children		Results: □ Normal □ Polyps □ Other
Birth control method	Miscarriages		
Birth control pill name			
Menopause symptoms			
Flushing			
Health Maintenance			
Date of last Pap smear	normal / abnormal		
Date of last mammogram	normal / abnormal		

Chart # ____________ Reviewed by ___________________________ Date ______________