

Methodist Mansfield Minimally Invasive Surgical Associates

Patient's name _____

Date of Birth _____

PATIENT HEALTH QUESTIONNAIRE (pg 1/2)

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)

Patient History	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine
<input type="checkbox"/> Ulcers	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Seizures	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> 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

<input type="checkbox"/> Diabetes F M S C R	<input type="checkbox"/> Thyroid Disease F M S C R	<input type="checkbox"/> Alcoholism F M S C R
<input type="checkbox"/> Hypertension F M S C R	<input type="checkbox"/> Heart Disease F M S C R	<input type="checkbox"/> Arthritis F M S C R
<input type="checkbox"/> Asthma F M S C R	<input type="checkbox"/> High Cholesterol F M S C R	<input type="checkbox"/> Seizures F M S C R
<input type="checkbox"/> Anemia F M S C R	<input type="checkbox"/> Osteoporosis F M S C R	<input type="checkbox"/> Glaucoma F M S C R
<input type="checkbox"/> Stroke F M S C R	<input type="checkbox"/> Migraine F M S C R	<input type="checkbox"/> Cancer F M S C R
<input type="checkbox"/> Obesity F M S C R	<input type="checkbox"/> Blood Clots F M S C R	

Chart # _____

Reviewed by _____ Date _____

Methodist Mansfield Minimally Invasive Surgical Associates

Patient's name _____

Date of Birth _____

PATIENT HEALTH QUESTIONNAIRE (pg 2/2)

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

General	Breast	Cardiac	Neurologic
<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Headache
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Discharge	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Dizziness
	<input type="checkbox"/> Mass	<input type="checkbox"/> Irregular pulse	<input type="checkbox"/> Seizures
Nutritional	Respiratory	<input type="checkbox"/> Leg pain when walking	<input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Weight loss > 10lbs	<input type="checkbox"/> Cough	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Passing Out
<input type="checkbox"/> Weight gain > 10lbs	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Varicose veins	
Skin	<input type="checkbox"/> Asthma / wheezing		
<input type="checkbox"/> Rash / hives	<input type="checkbox"/> Pneumonia		
<input type="checkbox"/> Psoriasis / Eczema	<input type="checkbox"/> Bronchitis		Endocrine
<input type="checkbox"/> New Skin Lesions		Urinary	<input type="checkbox"/> Heat or cold intolerance
<input type="checkbox"/> Change in Mole	Gastrointestinal	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Thirst
Eyes	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Loss of urinary control	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Eye irritation and itching	<input type="checkbox"/> Nausea / vomiting	<input type="checkbox"/> Frequent urination	
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Kidney Stones	
<input type="checkbox"/> Eye infections	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Urine Infections	Psychiatric
<input type="checkbox"/> Vision changes	<input type="checkbox"/> Abdominal pain (chronic)	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Sleeping difficulty
	<input type="checkbox"/> Change in bowel habits		<input type="checkbox"/> Depression
Ears	<input type="checkbox"/> Constipation		<input type="checkbox"/> Nervousness
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Memory loss
<input type="checkbox"/> Popping – pressure	<input type="checkbox"/> Bloody or Tarry stools	Genital	<input type="checkbox"/> Moodiness
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Gallbladder trouble	<input type="checkbox"/> Irritation/Infection	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Ear infections (frequent)	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Discharge	<input type="checkbox"/> Phobias
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sexual difficulties	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diverticulosis		Hematology
	<input type="checkbox"/> Colitis	Musculoskeletal	<input type="checkbox"/> Bruising
Nose	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Hernia	<input type="checkbox"/> Back pain	<input type="checkbox"/> Blood transfusions (lifetime)
<input type="checkbox"/> Runny nose		<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Enlarged lymph nodes
		<input type="checkbox"/> Joint injury	
Throat		<input type="checkbox"/> Gout	Allergies / Immune
<input type="checkbox"/> Sore throat		<input type="checkbox"/> Foot pain	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Hoarseness		<input type="checkbox"/> Cold / numb feet	<input type="checkbox"/> Frequent illnesses

FEMALES

MALE and FEMALE

Menstrual Flow	Have you had a colonoscopy? <input type="checkbox"/> Yes, Date: _____ <input type="checkbox"/> No
<input type="checkbox"/> Regular Days of flow Length of cycles	Results: <input type="checkbox"/> Normal <input type="checkbox"/> Polyps <input type="checkbox"/> Other
<input type="checkbox"/> Irregular <input type="checkbox"/> Pain / bleeding during or after sex	
<input type="checkbox"/> Pain / cramps	
Obstetric history	
Number of pregnancies Number of children	
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 _____