PLACER PRIVATE PHYSICIANS

Personalized family and sports medicine

Patient Health Questionnaire

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name:_____ Date:_____

DOB:_____ Age:_____ Email:_____

Previous established with: ☐ Dr. Hedman ☐ Dr. Lichti ☐ Dr. Brown ☐ New Patient

1. What medical concerns bring you to our office?

_____

_____

2. What is/are your health and wellness goals?

_____

_____

_____

3. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

4. Name of your spouse or significant other:

_____

5. Please describe your job / occupation: *(if retired, previous occupation)*

_____

6. If disabled, what is the nature of your disability?

_____

7. Do you feel you eat a healthy diet?

8. Please describe why or why not?

9. Do you exercise regularly? ☐ Yes ☐ No

10. If yes, what type of exercises and how many days per week?

11. Have you ever smoked? ☐ Yes ☐ No

12. If yes, number of cigars, cigarettes, or pipe a day: _____ Years smoking:_____

13. Do you still smoke now? ☐ Yes ☐ No

14. If no, when did you quit?

15. Do you drink alcohol? ☐ Yes ☐ No

16. If yes, how many drinks do you have per day or per week?

17. Have you ever tried to quit drinking alcohol? If yes, why?

18. Do you use any recreational drugs? ☐ Yes ☐ No

19. If yes, what drug(s)?

_____

_____

20. Have you ever tried to quit using a recreational drug? If yes, why?

_____

_____

21. Have you completed Advanced Directives or do you have a Living Will? If so, which?

_____

22. Do you drink caffeinated coffee, teas, or sodas regularly? Number a day?

_____

23. Tell us a little about your home environment: *(e.g. live alone, with family, single parent, house, apt.,pets, ect.)*

_____

_____

24. Are you under a lot of pressure at work or home? If so, which and why?

_____

_____

Medical Information

Allergies: Are you allergic to any drugs? ☐ Yes ☐ No

Please list with reactions.

_____

_____

Medications: List all medications you are taking regularly. Include over the counter, herbal or natural remedies.

Medical Illnesses or Conditions: List any chronic conditions which you have been diagnosed to have.

Have you ever been diagnosed to have: Check box by all that apply.

Cataracts		Heart Disease		Ulcers		Bone or Joint Disorders		Anemia	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Gout	
Asthma		High Blood Pressure		Hemorrhoids		Depression		Chicken Pox	
Allergies		Pneumonia		Kidney Disease		Frequent Infections		Thyroid Disease	
Prostate Enlargement		Seizures/Epilepsy		TB/Lung Disease		Syphilis			
Kidney Stones		Diabetes or Pre Diabetes		Pleurisy		High Cholesterol		Cancer (type)	
Stroke		German Measles		Jaundice or Liver Disease		Heart Attack or Angina			

Operations: Please list any surgery and approximate year.

Year	Operation

Hospitalizations: Other than operations.

Year	Reason	Hospital

Family Medical History	Age	Health (list significant illness)	Age at Death	If Deceased, List Cause	Comments
Mother					
Father					
Brother(s)					
Sister(s)					

Has any blood relative ever had any of the following: *(If yes, indicate relationship)*

☐	Alzheimer's	☐	Bleeding disease	☐	Alcoholism
☐	Tuberculosis	☐	Stroke	☐	Mental Disorder
☐	Diabetes	☐	Seizures	☐	Allergies
☐	High Blood Pressure	☐	Depression/Suicide	☐	Asthma
☐	Heart Disease	☐	Heart Attack Before age 55	☐	Cancer

Immunizations: Check if yes and indicate year of last injection.

☐	Influenza:	☐	Pneumonia:	☐	MMR:
☐	Tetanus:	☐	Hepatitis A or B:	☐	"Shingles":

Transfusions: Have you ever had a blood or plasma transfusion? ☐ Yes ☐ No

Weight: What is your weight now?_____One year ago?_____

Maximum weight and when? _____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No

Date of last menstrual period? _____

Systems review

Please indicate those items that have been **recurrent** or a **recent significant change**.

Yes	No	Constitutional Symptoms
☐	☐	Good health lately
☐	☐	Recent significant weight change
☐	☐	Unusual fatigue or weakness
☐	☐	Frequent headaches

		Eyes
☐	☐	Change in vision
☐	☐	Blurred or double vision
☐	☐	Eye disease or injury
☐	☐	Wear glasses/contact lenses

Yes	No	Ears/Nose/Mouth/Throat/Neck
☐	☐	Do you wear hearing aids
☐	☐	Hearing loss or ringing in ears
☐	☐	Earaches or drainage
☐	☐	Chronic sinus problems or runny nose
☐	☐	Nose bleeds
☐	☐	Mouth sores
☐	☐	Bleeding gums
☐	☐	Sore throat/hoarseness or voice change
☐	☐	Lumps or swollen glands in neck
☐	☐	Difficulty swallowing
☐	☐	Neck pain or stiffness

Yes	No	Musculoskeletal
☐	☐	Joint pain(s)
☐	☐	Joint stiffness/swelling or warmth
☐	☐	Weakness of muscles or joints
☐	☐	Muscle pain or recurrent cramps

Yes	No	Cardiovascular
☐	☐	Heart trouble
☐	☐	Chest pain or angina pectoris
☐	☐	Palpitations
☐	☐	Shortness of breath with walking or lying flat
☐	☐	Swelling feet, ankles or hands
☐	☐	Waking at night with shortness of breath

Yes	No	Respiratory
☐	☐	Chronic or frequent cough
☐	☐	Coughing or spitting up blood
☐	☐	Shortness of breath
☐	☐	Asthma or recurrent wheezing

Yes	No	Gastrointestinal
☐	☐	Loss of appetite
☐	☐	Change in bowel movements
☐	☐	Nausea or vomiting
☐	☐	Painful bowel movements or constipation
☐	☐	Rectal bleeding or blood in stool
☐	☐	Black or tarry stools
☐	☐	Stomach/abdominal pains or heartburn
☐	☐	Back pain

☐	☐	Cold hands or feet
☐	☐	Difficulty in walking
Yes	**No**	**Integumentary (Skin/Breasts)**
☐	☐	Rashes or itching
☐	☐	Change in skin color or moles
☐	☐	Change in hair or nails
☐	☐	Varicose veins
☐	☐	Breast pain
☐	☐	Breast lump
☐	☐	Breast discharge or rash

Yes	No	Neurological
☐	☐	Frequent, recurring or increasing headaches
☐	☐	Light-headedness or dizziness
☐	☐	Convulsions, seizures or spasms
☐	☐	Numbness or tingling sensations
☐	☐	Tremors
☐	☐	Paralysis
☐	☐	Stroke
☐	☐	Head injury

Yes	No	Psychiatric
☐	☐	Memory loss or confusion
☐	☐	Nervousness
☐	☐	Insomnia
☐	☐	Depression

Yes	No	Endocrine
☐	☐	Glandular or hormone problem
☐	☐	Heat or cold intolerance
☐	☐	Excessive skin dryness
☐	☐	Excessive thirst or urination
☐	☐	Change in hand or glove size

Yes	No	Hematologic / Lymphatic
☐	☐	Slow to heal after cuts or wounds
☐	☐	Bleeding or bruising tendency
☐	☐	Recurrent anemia
☐	☐	Swelling, warmth or tenderness of veins or history of phlebitis

Yes	No	Allergic / Immunologic
☐	☐	History of skin reaction or other adverse reaction to:
☐	☐	Penicillin or other antibiotic: describe reaction:
☐	☐	Morphine, Demerol or other narcotics reaction:
☐	☐	Novocain or other anesthetics reaction:
☐	☐	Aspirin or other pain remedies reaction:
☐	☐	Tetanus antitoxin or other serums
☐	☐	Iodine, methiolate or other antiseptic
☐	☐	Other medications:
☐	☐	Other known food allergies:

Yes	No	Genitourinary
☐	☐	Frequent urination burning or pain on urination blood in urine
☐	☐	Change in force or strain when urinating incontinence or dribbling of urine
☐	☐	Sexual difficulties
☐	☐	Men: Testicular pain
☐	☐	Women: Painful periods irregular periods or recurrent vaginal discharge

For women only:

Number of pregnancies (including miscarriages):_____

Number of deliveries:_____ Number of miscarriages:_____

Method of birth control (if applicable):_____

Menopausal since:_____

Date of last Pap:_____ Date of last menstrual period:_____

Date of last mammogram:_____

Emergency Contact Information

Name	Relationship	Phone Number

Preferred Pharmacy: Please list your preferred pharmacy

Name	Location	Phone

Additional Comments:

Patient Name: Date:

Signature: