Patient Health Questionnaire

Name____ Date______________

HAVE YOU EVER HAD ANY OF THE FOLLOWING

Asthma	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO
HIV or AIDS	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO	Kidney Problems	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	Dialysis	☐ YES	☐ NO
Blood Disorders	☐ YES	☐ NO	Chemotherapy	☐ YES	☐ NO
Immune Deficiencies	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO

Heart valve replacement? ☐ YES ☐ NO When? ___________________

Joint replacement in the last 24 months? ☐ YES ☐ NO

Radiation treatments to the head or neck? ☐ YES ☐ NO

Do you take blood thinners? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO

Do you smoke or use tobacco? ☐ YES ☐ NO

Are you or have you ever taken Fosamax or any medication (oral of IV) for Osteoporosis? ☐ YES ☐ NO

When? _________________ Dosage? ______________ How long?_____________________

_______________________ _____________________ ______________________________

Are you allergic to any medications of foods? ☐ YES ☐ NO Please list reactions. ______________________

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Please list all prescriptions or over the counter medication

__________________________ __________________________ ______________________________

__________________________ __________________________ ______________________________

__________________________ __________________________ ______________________________

__________________________ __________________________ ______________________________

Please list any surgeries, serious illnesses or hospitalizations and dates they occurred

__________________________ _________________________ _____________________________

__________________________ _________________________ _____________________________

__________________________ _________________________ _____________________________

Have you had anything to eat or drink in the last 6 hours? ☐ YES ☐ NO

I certify that the above information is true to the best of my knowledge

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Signature