

PATIENT HEALTH QUESTIONNAIRE



6345 S. 56th Street Suite 100
 Lincoln NE 68516
 402.420.0020 fax 420.420.0014

Name: _____
 Weight: _____ Height: _____ Age: _____ Sex: _____

Have you or any immediate family member have a history of: (Check all that apply)

	You	Family		You	Family
Cancer			High blood pressure		
Diabetes			Heart disease		
Stroke			Angina/ chest pain		
Arthritis			Shortness of breath		
Allergies			Asthma		
Bronchitis			Kidney Disease		
Polio			Emphysema		
Anemia			Ulcers		

With this current problem do you experience: (Check all that apply)

- | | | |
|--------------------------|------------------|---------------------------|
| Nausea/vomiting | Dizziness | Fevers/ chills/ sweats |
| Night pain | Headaches | Unexplained weight change |
| Muscular weakness | Surgery | Numbness or tingling |
| Bowel or bladder changes | Other (explain): | |

Have you received treatment for this problem?

No Yes (please explain):

Have you had any recent illness, to include upper respiratory infections, flu, or urinary tract infections?

No Yes (please explain):

Do you use caffeine? No Yes Do you smoke? No Yes

Do you drink alcohol? No Yes Is stress a factor in your life? No Yes

Date of last complete physical examination:

Please list all medications and supplements:

Signature: _____ Date: _____