

# PATIENT HEALTH QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## MEDICAL HISTORY

<p><b>Please circle the appropriate response:</b></p> <p>Are you currently taking any medications?      <b>YES</b>      <b>NO</b></p> <p>Which ones?(Name &amp; Dosage)_____</p>	<p><b>ANY OTHER PERTINENT MEDICAL HISTORY:</b></p> <p>_____</p> <p>_____</p>
<p>Are you <b>allergic</b> to any medications?      <b>YES</b>      <b>NO</b></p> <p>List the medication &amp; the reaction it caused:</p> <p>_____</p>	<p><b>PLEASE LIST ALL PREVIOUS SURGERIES AND DATES:</b></p> <p>_____</p> <p>_____</p>
<p><b>DO YOU EXPERIENCE:</b></p> <p><b>Blood pressure problems</b>      <b>YES</b>      <b>NO</b></p> <p><b>Mitral valve prolapse or heart murmur</b>      <b>YES</b>      <b>NO</b></p> <p><b>Chest pain</b>      <b>YES</b>      <b>NO</b></p> <p><b>Pacemaker or Defibrillator</b>      <b>YES</b>      <b>NO</b></p> <p><b>Do you take Aspirin or anti-inflammatory medications?</b>      <b>YES</b>      <b>NO</b></p> <p>Which ones?_____</p> <p><b>Do you take blood thinners? i.e.Plavix, Coumadin. Which ones?</b>      <b>YES</b>      <b>NO</b></p> <p><b>Have you had :a positive HIV diagnosis?</b>      <b>YES</b>      <b>NO</b></p> <p style="padding-left: 40px;"><b>:Hepatitis A, B or C</b>      <b>YES</b>      <b>NO</b></p> <p style="padding-left: 40px;"><b>:Syphilis</b>      <b>YES</b>      <b>NO</b></p> <p><b>Do you have Diabetes</b>      <b>YES</b>      <b>NO</b></p> <p><b>History of thickening or spreading scars</b>      <b>YES</b>      <b>NO</b></p> <p><b>Family Doctor:</b>_____</p> <p>Would you object to our office contacting your family doctor in regard to any medical problem that may arise?      <b>YES</b>      <b>NO</b></p> <p>Have you ever had any adverse reaction to local anesthesia?      <b>YES</b>      <b>NO</b></p> <p>Please describe:_____</p> <p>History of blood clots      <b>YES</b>      <b>NO</b></p> <p>History of <b>blood transfusion</b>      <b>YES</b>      <b>NO</b></p> <p>Bleeding tendency or excessive bleeding      <b>YES</b>      <b>NO</b></p> <p>Do you take vitamin E?      <b>YES</b>      <b>NO</b></p> <p>Do you exercise regularly?      <b>YES</b>      <b>NO</b></p> <p><b>History of skin cancer?</b>      <b>YES</b>      <b>NO</b></p> <p><b>Please Circle Below</b></p> <p><b>Basal Cell, Squamous Cell, or Melanoma</b></p> <p><b>Steven M. Rotter M.D.</b> _____</p>	<p><b>DO YOU HAVE:</b></p> <p>An Advance Directive, Living Will or POA?      <b>YES</b>      <b>NO</b></p> <p>If so please provide a copy.</p> <p><b>DO YOU:</b></p> <p>Smoke or have a history of smoking?      <b>YES</b>      <b>NO</b></p> <p>How much?_____</p> <p>Drink alcohol?      <b>YES</b>      <b>NO</b></p> <p>How much?_____</p> <p>Think you are pregnant?      <b>YES</b>      <b>NO</b></p> <p>Date of last menstrual cycle:_____</p> <p><b>HAVE YOU HAD:</b></p> <p>Kidney disease      <b>YES</b>      <b>NO</b></p> <p>Liver or gallbladder problems      <b>YES</b>      <b>NO</b></p> <p>Abdominal or inguinal hernia      <b>YES</b>      <b>NO</b></p> <p>History of leg swelling      <b>YES</b>      <b>NO</b></p> <p>Thyroid problems      <b>YES</b>      <b>NO</b></p> <p>Glaucoma or cataracts      <b>YES</b>      <b>NO</b></p> <p>Dry eyes      <b>YES</b>      <b>NO</b></p> <p><b>Herpes or Cold Sores</b>      <b>YES</b>      <b>NO</b></p> <p>Musculoskeletal pain      <b>YES</b>      <b>NO</b></p> <p>Explain:_____</p> <p>Artificial joints      <b>YES</b>      <b>NO</b></p> <p>Explain:_____</p> <p>Radiation treatment for any condition      <b>YES</b>      <b>NO</b></p> <p>Explain:_____</p> <p>Psychiatric condition      <b>YES</b>      <b>NO</b></p> <p>Any treatment for nervous condition      <b>YES</b>      <b>NO</b></p> <p>Explain:_____</p> <p><b>Patient Signature:</b>_____</p> <p><b>Surgical Assistant :</b>_____</p>