



## PATIENT HEALTH QUESTIONNAIRE (CONT.)

10. Please check any of the following which apply:

PAST / PRESENT

Neck Pain  
 Jaw Pain  
 Tinnitus (ringing in ears)  
 Chronic cough  
 Chronic Sinusitis  
 Foot/Ankle  
 Loss of appetite  
 Muscular incoordination  
 Leg Pain  
 Dizziness  
 Rapid Heart Beat  
 Abnormal Change in weight  
     *Loss      Gain*

PAST / PRESENT

Hand Pain  
 Shoulder  
 Chest Pains  
 Excessive Thirst  
 Wrist Pain  
 Upper back  
 Lower back  
 Arm or Elbow  
 Headache  
 Convulsions  
 Dizziness

11. Please list: Height: \_\_\_\_\_ Weight: \_\_\_\_\_

12. Please check any of the following that apply to you:

Smoking/Tobacco use \_\_\_\_\_  
 Alcohol use & frequency \_\_\_\_\_  
 Coffee/Tea/Caffeinated Soft drinks & cups per day \_\_\_\_\_  
 Birth Control Pills used \_\_\_\_\_  
 Medications (please list all) \_\_\_\_\_  
 \_\_\_\_\_  
 Surgical Procedures (please list all) \_\_\_\_\_  
 \_\_\_\_\_

12. Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the are presently troubled by a listed disorder.

PAST / PRESENT

Depression  
 Angina  
 Heart Attack  
 Stroke  
 Asthma  
 Blood Disorder

PAST / PRESENT

Emphysema  
 Arthritis  
 Diabetes  
 Ulcer  
 Kidney Stone  
 Bladder Infection

PAST / PRESENT

Colitis  
 Irritable Colon  
 HIV/AIDS  
 Aortic aneurysm  
 High blood Press

13. Please use the space below to specify any other information you feel would assist the doctor with your consultation today:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_