Family Physicians of O'Fallon

Patient Health Questionnaire

Patient Name: _____
First Last Middle initial

Address: _____

Home phone / cell phone: _____

Date of Birth: _____ Day / Month / Year

Which provider will you be seeing? _____

Appointment date and time: _____

Past Medical History

Past Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

GYN History (females only):

_____ Pregnancies _____ Live Births _____ Miscarriages

Current Method of Pregnancy Prevention: _____

List Past Surgeries: Include dates if known

_____
_____
_____
_____
_____

List previous hospitalizations: (Other than childbirth or surgeries)

_____
_____

Specialists you are seeing: (Name and specialty)

_____

_____

Please indicate the following by either date, unknown, never, or not applicable.

Last Tetanus shot_____
Gardasil series completed (if female 9-26)_____
Last Flu shot _____
Last Pneumonia shot_____
Last Zostavax (shingles)_____

Last Pap smear (female) _____
Last Mammogram (female) _____
Last Bone Density Scan (if applicable) _____
Last Colonoscopy_____ Due date for next colonoscopy (if applicable) _____

Last PSA blood test (male)_____

List Current Medications: (Include Medications, Vitamins, Herbs, and Supplements)

Name dose how often you take **reason for taking**

_____
_____
_____
_____
_____
_____
_____

List Known Drug Allergies:

_____
_____

Social History (circle correct answer and fill in blanks)

Currently Smoke: Yes ____ No _____

If yes, how much do you smoke and for how long? _____

Have you ever smoked in the past? Yes _____ No _____

If you quit, how long did you smoke, how much did you smoke, and when did you quit?

_____

Chewing Tobacco: Yes _____ No _____

Alcohol Consumption: Yes _____ No _____

How many drinks on average per day/week _____
How many drinks per setting _____
1 drink = 12oz beer, 4oz wine, 1.5oz liquor

Illicit/ Illegal drug usage: Yes No
Current Drugs Used:_____

Past drugs Used:_____

Marital Status: Married widowed single divorced separated

Children: Yes No How many_____

Occupation: _____

Exercise Habits: _____

Dairy / Milk intake: _____

Daily Caffeine intake: (coffee, tea, soda, chocolate, and energy drinks): _____

Family History (circle answer and fill in applicable blanks)

For each listed below please living or deceased at what age, current medical conditions and / or cause of death

Father: living/deceased at age ___ medical conditions:_____

_____

Mother: living/deceased at age ___ medical conditions:_____

_____

Brother: living/deceased Medical conditions: _____

Brother: living/deceased Medical conditions: _____

Brother: living/deceased Medical conditions: _____

Brother: living/deceased Medical conditions: _____

Sister: living/deceased Medical conditions:_____

Sister: living/deceased Medical conditions:_____

Sister: living/deceased Medical conditions:_____

Sister: living/deceased Medical conditions:_____

Maternal Grandfather: living/ deceased Medical conditions:_____

Maternal Grandmother: living/ deceased Medical conditions:_____

Paternal Grandfather: living/ deceased Medical conditions:_____

Paternal Grandmother: living/ deceased Medical conditions:_____

Any other family members with the following diseases or condition?
Diabetes, High Blood Pressure, Cancer, Heart Disease, Stroke, DVTs, Kidney Disease

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_____