IHA Rheumatology Consultants
Patient Health Questionnaire

MD Signature/date______________________________________

MA Signature/date______________________________________

Date____

Name____ Date of Birth____

Address____ City/State/Zip____

Home Phone_______________________________________ Emergency Contact Name/Phone______________________________

Employer____ Employer Phone____

Occupation____ Marital Status____

Physician Information:

Primary Care Physician______________________________ Referring Physician____

Street Address_____________________________________ Street Address____

City/State/Zip______________________________________ City/State/Zip____

Phone____ Phone____

Chief Complaint (*reason for your appointment*)____

____

Previous History: (*please try to be complete about dates, hospitals, doctors and therapies*)

Past or Known Medical History (ex: high blood pressure, high cholesterol, diabetes, cancer, etc.): ________________________

____

____

Past Surgical History:____

____

____

Social History:

Cigarettes/Cigar/Pipe: amount per week______________________________per day__________________________

Smokeless (chew): amount per week______________________________per day__________________________

Age at onset________________any change in pattern____________________duration of smoking________________

How would you describe your use of alcohol?____

Amount per week: beer__________________wine______________________liquor________________________

Use of recreational and intravenous drugs: Yes___________ No_____________

Have you ever attended or felt you should attend a drug or alcohol rehabilitation program?____________________________

If yes, please explain____

Do you consume caffeine?____________Type?_________________ How much daily? __________________________

OVER

Patient Name______________________________
Date of Birth______________________________

PLEASE COMPLETE ALL PAGES

Family History: Please circle any condition appearing below that any blood relative has had. Please name the relationship (e.g. Father, Sister, Etc.)

Heart attack – at what age____________________ Emphysema_________________________ Diabetes_________________________

Rheumatoid Arthritis________________________ High Blood Pressure_________________ Asthma__________________________

Crohn's disease____________________________ Colon Cancer_______________________ Colitis ___________________________

Anemia (low blood)________________________ Allergies___________________________ Lupus___________________________

Seizure or epilepsy_________________________ Tuberculosis_______________________ Stroke___________________________

Breast Cancer______________________________ Easy Bleeding/bruising______________ Alcoholism_______________________

Cirrhosis__________________________________ Cholesterol Problem_________________ Thyroid Trouble___________________

Irritable Bowel Disease______________________
(spastic colon)
Do any other diseases run in your family?____

Medicines: List all prescription medications and over the counter medications that you take.

☐ **NONE**

Medication	Dose	Frequency

Allergies: List all medications/substances that you are allergic to and the reaction you have/had.

☐ **NONE**

Medication/Substance	Reaction

OVER

Patient Name_______________________________
Date of Birth______________________________

PLEASE COMPLETE ALL PAGES

Review of Systems: (please circle any symptoms you have/had)

Constitutional
Fatigue
Weight loss____lbs
Weight gain____lbs
Change in appetite
Insomnia
Night sweats
Sweating
Fever

HEENT
Headache
Ringing in ears
Deafness/hearing loss
Change in vision
Foreign body sensation In eyes
Hoarseness
Nosebleeds
Mouth sores
Dry mouth
Dry eyes

Neurological
Paralysis
Loss of sensation
Dizziness
Seizures
Tremor
Stroke

Gastrointestinal
Abdominal distention
Abdominal pain
Constipation
Diarrhea
Blood in stool
Foul smelling black, tarry stool
Nausea
Vomiting
Vomiting blood
Heartburn
Difficulty swallowing
Painful swallowing
Jaundice
Hepatitis/liver problem

Metabolic/Endocrine
Excessive hair growth
Hair loss
Change in sleep pattern
Sleeping too much
Shakiness
Intolerance to heat/cold

Dermatological
Sensitivity to sun
Rash

Mental Health
Depressed mood
Loss of interest in work
Social withdrawal
Difficulty concentrating
Memory loss
Guilty feelings
Loss of sexual desire
Feeling of hopelessness and helplessness
Anxiety
Nervousness
Tension
Thoughts of suicide
Hearing voices
Visual hallucinations

Musculoskeletal
Gout
Back pain
Leg pain
Weakness
Muscle weakness
Abnormal movement
Joint pain/stiffness
Neck stiffness

Respiratory
Cough
Coughing up blood
Shortness of breath
Chest pain on inspiration
Wheezing
Snoring

Cardiovascular
Chest pain
Palpitations
Heart attack
High blood pressure
Fainting
Ankle swelling

Genitourinary
Pain on urination
Frequent urination
Blood in urine
Flank pain
Kidney stones

Hematological
Blood clots
Anemia
Low blood counts
Easy bruising

LEARNING
Is there anything that makes learning difficult for you? (circle all that apply)
No difficulties Fatigue/Pain Vision Problems Hard of Hearing Language Problems

What is the easiest way for you to learn? Reading Pictures Listening Being Shown

RELIGIOUS/CULTURAL
Do you have any religious or cultural practices that might affect or be affected by the health care services that we provide?
NO YES-explain______________________________

What is your preferred language to discuss your health related information and concerns? (please circle one)
English Spanish Sign Language Other_________________

Which of these best describes your race? (please circle one)
Asian Black/African American White/Caucasian Multiracial Native American Declined Other_______________

What is your ethnicity? (please circle one)
Hispanic Not of Hispanic Origin Declined Unknown

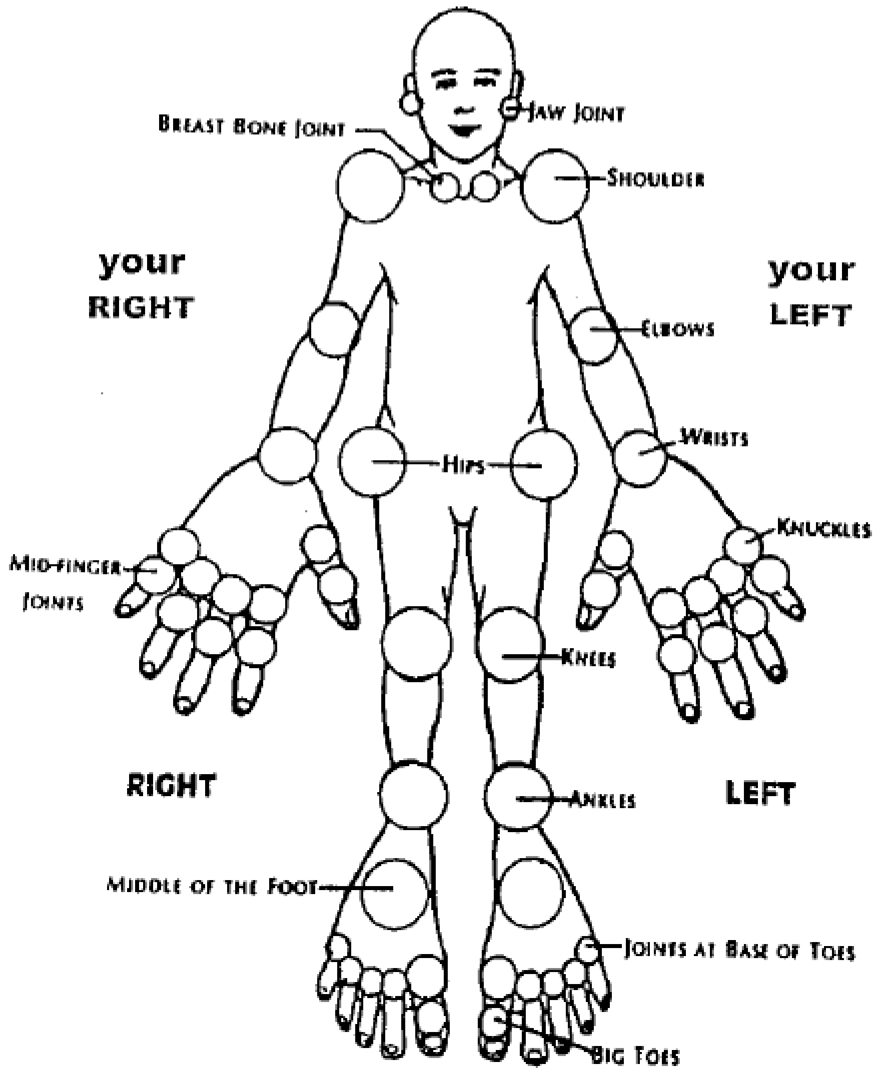
Have you fallen recently?
NO YES - date__________________________

Do you currently use an assistive device?
NO YES – Walker Cane Crutches (please circle)

OVER

Patient Name_____________________________
Date of Birth_____________________________

PLEASE MARK (X) JOINTS WHICH ARE PAINFUL



*** For Office Use Only ***

Observation: Steady Unsteady MD Signature______________________

FALL RISK: Low High MA Signature______________________

Reviewed by:__________________________ date/time____________________________