Methodist Charlton Ear, Nose, and Throat **Patient's name**_____
PATIENT HEALTH QUESTIONNAIRE (pg 1/2) **Date of Birth**_____

Gender M / F Marital Status S M W D Sep

Reason for visit _____

When was your last Tetanus Shot: _____ Have you had the flu shot this year? □ Yes □ No

Medical History (Mark all that apply)

Childhood Illnesses	□ Rheumatic fever	□ Mumps	□ Scarlet fever	□ Chicken pox	□ Polio	□ Measles
Patient History	□ Diabetes Mellitus	□ Asthma	□ Hypertension	□ Heart Disease	□ Glaucoma	□ Migraine
□ Ulcers	□ High Cholesterol	□ Stroke	□Tuberculosis	□ Kidney Disease	□ Cancer	□ Depression
□ Arthritis	□ Thyroid Disease	□ Anemia	□ Osteoporosis	□ Alcoholism	□ Seizures	□ Mental Illness
□ Hepatitis	□ Other (please list)					

Drug Allergies: _____
Current Medications (including non-prescription medications and supplements):_____
_____
_____
_____
Last doctor's visit _____ **Doctor's name** _____
Hospitalizations_____
_____
Surgeries _____
_____

Social History
Occupation _____ Hours/week: _____ Satisfied with job: _____
Alcohol _____drinks per week Coffee / Tea _____cups/day
Tobacco: Smoking _____ cigarettes/day # Years:_____ Year quit:_____
Chewing _____cans/week # Years: :_____ Year quit: _____
Recreational drugs _____ Last used:_____
Do you follow a particular diet? (explain) _____
Do you exercise regularly? _____

Family History: (If any relative has suffered any of the following, mark and indicate which relative)
F – Father M – Mother S – Sibling C – Child R – Other Relative

□ Diabetes F M S C R	□ Thyroid Disease F M S C R	□ Alcoholism F M S C R
□ Hypertension F M S C R	□ Heart Disease F M S C R	□ Arthritis F M S C R
□ Asthma F M S C R	□ High Cholesterol F M S C R	□ Seizures F M S C R
□ Anemia F M S C R	□ Osteoporosis F M S C R	□ Glaucoma F M S C R
□ Stroke F M S C R	□ Migraine F M S C R	□ Cancer F M S C R

Chart # _____ Reviewed by _____ Date _____

Methodist Family Health Centers **Patient's name**_____
PATIENT HEALTH QUESTIONNAIRE (pg 2/2) **Date of Birth**_____

Systems Review: Check any of the following which you have had in the last 3 months

General	**Breast**	**Cardiac**	**Neurologic**
□ Fever or chills	□ Tenderness	□ Chest pain	□ Headache
□ Fatigue	□ Discharge	□ Swollen ankles	□ Dizziness
		□ Irregular pulse	□ Seizures
Nutritional	**Respiratory**	□ Leg pain when walking	□ Numbness or tingling
□ Weight loss	□ Cough	□ Heart murmur	□ Tremor
	□ Shortness of breath	□ Varicose veins	□ Muscle weakness
Skin	□ Asthma / wheezing	□ Phlebitis	□ Passing out
□ Rash / hives	□ Pneumonia		
□ Psoriasis / Eczema	□ Bronchitis	**Urinary**	**Endocrine**
□ New moles		□ Painful urination	□ Heat or cold intolerance
	Gastrointestinal	□ Loss of urinary control	□ Thirst
Eyes	□ Heartburn	□ Frequent urination	□ Frequent urination
□ Eye irritation and itching	□ Nausea / vomiting	□ Urination>2x nightly	
□ Eye pain	□ Loss of appetite	□ Decreased force or flow	**Psychiatric**
□ Eye infections	□ Difficulty swallowing	□ Blood in urine	□ Sleeping difficulty
□ Vision changes	□ Abdominal pain (chronic)	□ Kidney stones	□ Depression
	□ Change in bowel habits	□ Urine infections	□ Nervousness
Ears	□ Constipation		□ Memory loss
□ Ear pain	□ Diarrhea	**Genital**	□ Moodiness
□ Popping – pressure	□ Bloody or Tarry stools	□ Irritation/Infection	□ Mental illness
□ Ringing in ears	□ Gallbladder trouble	□ Discharge	□ Phobias
□ Ear infections (frequent)	□ Jaundice	□ Sexual difficulties	
□ Hearing loss	□ Hepatitis		**Hematology**
□ Dizziness	□ Diverticulosis	**Musculoskeletal**	□ Bruising
	□ Colitis	□ Joint pain	□ Bleeding
Nose	□ Hemorrhoids	□ Back pain	□ Blood transfusions (lifetime)
□ Sinus trouble	□ Hernia	□ Bone fracture	□ Enlarged lymph nodes
□ Runny nose		□ Joint injury	
		□ Gout	**Allergies / Immune**
Throat		□ Foot pain	□ Seasonal allergies
□ Sore throat		□ Cold / numb feet	□ Frequent illnesses
□ Hoarseness			

FEMALES	**MALES**
Menstrual Flow	Prostate exam date
□ Regular Days of flow Length of cycles	PSA Test date
□ Irregular □ Pain / bleeding during or after sex	
□ Pain / cramps	**MALE & FEMALE**
Obstetric history	Have you had a colonoscopy? □ **Yes** □ **No** **Date:**
Number of pregnancies Number of children	Results: □ Normal □ Polyps □ Other
Birth control method Miscarriages	
Birth control pill name	
Menopause symptoms	
Flushing	
Health Maintenance	
Date of last Pap smear normal / abnormal	
Date of last mammogram normal / abnormal	

Chart # _____ Reviewed by _____ Date _____