IHA Rheumatology Consultants
Patient Health Questionnaire

MD Signature/date_____
MA Signature/date_____

Date_____

Name_____ Date of Birth_____

Occupation_____ Marital Status_____

Physician Information:

Primary Care Physician_____ Referring Physician_____

Pharmacy Information:

Preferred Pharmacy Name: _____ Pharmacy Location: _____

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:_____

_____

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** **OVER**

Medication/Substance	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Name_____ Date of Birth_____

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

Social History:

Are you a smoker?
☐ Yes, every day ☐ No, have never smoked ☐ Yes, some days ☐ No, I am a former smoker

Do you use any other form of tobacco?
☐ Yes ☐ No If yes, what _____

Do you drink **alcoholic beverages**? ☐ Yes ☐ No Amount per week: _____
If you drink, what type of alcohol do you drink? _____

Do you consume **caffeine**? ☐Yes ☐ No Amount per day: _____
If you do, what type? (*example: coffee, tea, chocolate, etc.*) _____

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

Rheumatod Arthritis_____Psoriasis_____Lupus_____

Other Auto Immune Diseases _____High Blood Pressure_____Asthma_____

Diabetes_____Cancer/ Type_____Colitis_____

Anemia (low blood)_____ Cirrhosis_____ Easy Bleeding/bruising_____

Tuberculosis_____ Stroke_____ Heart attack – at what age_____

Emphysema _____ Alcoholism_____ Thyroid Trouble_____

Do any other diseases run in your family?_____

Name_____ Date of Birth_____

PLEASE MARK (X) JOINTS WHICH ARE PAINFUL