

PATIENT HEALTH QUESTIONNAIRE

2 of 2

<p>PLEASE CIRCLE BELOW MEDICAL PROBLEMS OF RELATIVES:</p> <p>Mother: CANCER LIVER HEART DIABETES STROKE PSYCHIATRIC</p> <p>Father: CANCER LIVER HEART DIABETES STROKE PSYCHIATRIC</p> <p>Brother: CANCER LIVER HEART DIABETES STROKE PSYCHIATRIC</p> <p>Sister: CANCER LIVER HEART DIABETES STROKE PSYCHIATRIC</p> <p>Aunt: CANCER LIVER HEART DIABETES STROKE PSYCHIATRIC</p> <p>Uncle: CANCER LIVER HEART DIABETES STROKE PSYCHIATRIC</p> <p>Grandpa: CANCER LIVER HEART DIABETES STROKE PSYCHIATRIC</p> <p>Grandma: CANCER LIVER HEART DIABETES STROKE PSYCHIATRIC</p>	<p>LIST HOSPITAL STAYS (SURGERY OR ILLNESS) WITH DATE OR AGE AT TIME:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>HAVE YOU HAD VACCINE FOR HEPATITIS A? Y__N__ DOSE 1__ DOSE 2__ DOSE 3__</p> <p>HAVE YOU HAD VACCINE FOR HEPATITIS B? Y__N__ DOSE 1__ DOSE 2__ DOSE 3__</p>
<p>PLEASE CHECK EITHER YES OR NO TO THE FOLLOWING QUESTIONS: IF YES, PLEASE FILL IN THE FOLLOWING:</p> <p>Have you EVER injected drugs with a needle (even if only once)? NO__YES__ Date or age 1st used_____ Date or age last used_____</p> <p>Have you EVER snorted cocaine through your nose (even if only once)? NO__YES__ Date or age 1st used_____ Date or age last used_____</p> <p>Have you EVER had a blood transfusion? NO__YES__ How many times?_____ Dates (or age) of each_____</p> <p>Have you EVER had an accidental needle stick? No__YES__ How many times?_____ When?_____ Where were you?_____</p> <p>Have you EVER had kidney dialysis? NO__YES__ When?_____</p> <p>Have you EVER had an organ transplant? NO__YES__ When?_____</p> <p>Does your mother have Hepatitis C? NO__YES__ Did she have Hepatitis C before you were born? NO__YES__</p> <p>Have you EVER had unsafe sex (with a drug user or prostitute) or a sexual disease? NO__YES__ Date or age of 1st_____ Date or age of last_____</p> <p>EVER had any body piercing, tattoos, or acupuncture? NO__YES__ What was done? How many? Where done?(ex.Prison) Date of 1st? Date of last?</p> <p>Explain: _____</p>	
<p>PLEASE ONLY CHECK MARK THAT ARE TRUE FOR YOU:</p> <p>TOBACCO USE: NEVER__QUIT__DATE QUIT_____ STILL SMOKE:___ HOW MANY MTHS/YEARS?_____ HOW MUCH DO YOU SMOKE?_____</p> <p>ALCOHOL USE: NEVER__QUIT__DATE QUIT_____ STILL DRINK:___ HOW MANY MTHS/YEARS?_____</p> <p>WHAT DO YOU DRINK? (EX. Wine, whiskey, rum, vodka, beer)_____ HOW MUCH DO YOU DRINK?:_____</p> <p>HOW OFTEN DO YOU DRINK?: 1-2 DAY/WK__ 3-4 DAY/WK__ 5-6 DAY/WK__ DAILY__</p>	
<p>LIST MEDICATIONS, DOSAGES, HERBS, VITAMINS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>ALLERGIC TO ANY MEDICATION?: NO__YES__</p> <p>PLEASE LIST MEDICINE BELOW AND REACTION EXPERIENCED:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

PATIENT HEALTH QUESTIONNAIRE

Page 1 of 2

NAME: _____ LAST FOUR: _____ DATE: _____ PLEASE CHECK IF: SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___

DO YOU HAVE OR HAVE YOU EVER HAD ANY MEDICAL PROBLEMS WITH: IF YES, PLEASE CHECK EACH OR ALL THAT APPLY:

Heart Yes No Angina ___ Heart Attack ___ Murmur ___ Congestive Heart Failure ___ Irregular Beats ___ Abnormal rate ___ Surgery ___
 Blood Pressure Yes No High ___ Low ___ On Medication: Yes ___ No ___
 Diabetes Yes No Controlled: Yes ___ No ___ Treated with diet and exercise ___ Treated with oral med ___ Treated with insulin ___
 Thyroid Yes No Overactive ___ Underactive ___ On Medication: Yes ___ No ___
 Bleeding from Mouth Yes No Number of Times ___ Dates ___ Hospital Admits ___ Scoped ___ Other exams/tests (what?) ___
 Bleeding from Rectum Yes No Number of Times ___ Dates ___ Hospital Admits ___ Scoped ___ Other exams/tests (what?) ___
 Anemia Yes No Name of Anemia ___ Date Diagnosed ___ Complications/transfusions: Yes ___ No ___
 Depression Yes No On Medication: Yes ___ No ___ Controlled: Yes ___ No ___ Feel like ending your life?: Yes ___ No ___
 Suicide Attempts Yes No How Many Times: ___ Dates ___ Method(s) Used ___ If Used Drugs, Please List _____

CHECK IF YOU EVER HAD:

HIV ___ Hepatitis B ___ TB ___ Autoimmune Disease ___ COPD ___ Cancer ___ Retina Problems ___ Stroke ___ Treatment for Hepatitis C or B _____

PLEASE CHECK BELOW ONLY PROBLEMS YOU ARE CURRENTLY EXPERIENCING:

General: Weight Changes ___ Weakness ___ Fatigue ___ Fever ___ Swollen/painful lymph nodes ___
 Head/Neurological: Headaches ___ Seizures ___ Fainting ___ Blackouts ___ Paralysis ___
 Memory: Decrease ___ Trouble with solving problems ___ Trouble with thinking ___
 Balance/Coordination: Falling ___ Unsteady ___ Dizziness ___
 Eyes/Ears/Nose: Pain ___ Discharge ___ Vision Changes ___ Hearing Changes ___ Sense of Smell Changes ___
 Breathing: Pain with Breathing ___ Shortness of Breath ___ Cough ___ Blood With Cough ___ Wheezing ___
 Heart: Chest Pain ___ Skipped Beats ___ Rapid Beats ___
 Swallowing: Pain with swallowing ___ Food stick to throat ___ Fluids stick to throat ___ Lump in throat ___
 Stomach/Abdomen: Pain ___ Nausea ___ Vomiting ___ Vomit with Blood ___ Acid Reflux ___ Heart Burn ___
 Bowel Habits: Change in size/frequency ___ Pain ___ Diarrhea ___ Constipation ___ Blood (Bright Red or Tarry Black) ___
 Urination: Change in volume or frequency ___ Pain ___ Change in color ___ Blood ___
 Sexual Organs: Change in sex drive ___ Pain ___ Rash or Sores ___ Swelling or lumps ___ Discharge ___
 Joints/Muscles: Pain ___ Swelling ___ Redness ___ Stiffness ___
 Arms/Legs: Pain at Rest ___ Pain with Movement ___ Decreased motion ___ Swelling ___ Edema ___ Discoloration ___
 Back: Pain ___ Nerve or Disc injury ___ Decreased Motion ___
 Skin: Rash ___ Itch ___ Pain ___ Open Sores ___ Lumps ___ Color Change ___ Change in a mole ___

FEMALES ONLY:

Date of Last Menstrual Period: _____
 How Many Pregnancies?: _____
 How Many Childbirths?: _____
 Number of Children: _____

PLEASE COMPLETE IF YOU HAVE CHILDREN:

AGE	HEP C POS	HEP C NEG	Don't Know

Have YOU ever lived with someone Hepatitis C Positive?: Yes ___ No ___ Don't Know ___ If Yes, Who? _____

PLEASE COMPLETE THE BACK