Medicine Associates of North Texas

Patient Health Questionnaire

Patient's Name: _____

Date: _____

Family History:

	Age	Alive or Deceased	Illnesses	Cause of Death
Father				
Mother				
Bothers				
Sisters				
Children				

Have any of your relatives had any of the following?

	Yes	No	Relationship
Diabetes Mellitus			
Stroke			
Heart Disease			
High Blood Pressure			
Cancer			

Social History: Yes or No

Do you use Alcohol? _____ If so, how much? _____

Do you use Tobacco? _____ If so, how much? _____

What is your occupation? _____

Past Medical History:

Surgeries: 1._____
2. _____
3. _____
4. _____
5. _____
6. _____

Medical Illnesses: 1._____
2._____
3._____
4._____
5._____
6._____

Medications: _____
_____
_____
_____
_____

Drug Allergies/Reactions

Drug: _____ Reaction: _____
_____ _____
_____ _____
_____ _____

GYN HISTORY:

Pregnancies: Deliveries: Miscarriages: Abortions:

DO NOT WRITE BELOW THIS LINE

Health Maintenance	**Date of Test**								
Complete Physical Exam									
Well Women/Pap									
Breast Exam									
Mammogram									
Prostate Exam									
Stool Guaiac									
Flu Shot									
Pneumonia shot									
Tetanus Shot									
EKG									
PSA									
TSH									
Glycohempglobin									
Eye Exam (Diabetic)									