andrewTRUSSLERmd

Patient Health Questionnaire

Please help us assure you the highest quality of care by answering carefully.

DEMOGRAPHICS

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____ SSN: XXX - XX - _____ Sex: _____

Date of Surgery: _____

TODAY'S VISIT

Age on this visit: _____ Occupation: _____

Personal Physician: _____ Specialty: _____

Address: _____ Phone: _____

Date of last exam: _____ Results: _____

Whom may we thank for this referral?: _____

This consultation is to discuss: _____

CURRENT MEDICATIONS

1. Medication: _____ Dosage: _____ Last Time Taken: _____
2. Medication: _____ Dosage: _____ Last Time Taken: _____
3. Medication: _____ Dosage: _____ Last Time Taken: _____
4. Medication: _____ Dosage: _____ Last Time Taken: _____
5. Medication: _____ Dosage: _____ Last Time Taken: _____

MEDICAL HISTORY

Please check appropriate box(es) if you currently have, or have had, any of the following:

- ☐ Prolonged bleeding when cut
- ☐ Fainting or blackout episodes
- ☐ High blood pressure
- ☐ Ulcer disease
- ☐ Heart disease and/or heart attack
- ☐ Irregular heart beat, palpitations
- ☐ Blood disorders (anemia, etc.)
- ☐ Thyroid problems
- ☐ Herpes, fever blisters
- ☐ Skin disorders
- ☐ Eyes: burning, dryness, itching
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Hepatitis
- ☐ Lung/respiratory problems
- ☐ Shortness of breath
- ☐ Swelling of ankles
- ☐ Cancer
- ☐ Immune disorders
- ☐ Heart murmur
- ☐ Heart valve disorder
- ☐ Rhumatic Fever

Are you pregnant? ☐ NO ☐ YES

Date of last menstrual period: _____

How many pregnancies: _____

If you answered yes to any of the above, please explain: _____

_____

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SURGICAL HISTORY

Previous procedures and when they occurred:

COSMETIC:

- ☐ Eye: _____
- ☐ Ear: _____
- ☐ Nose: _____
- ☐ Face: _____
- ☐ Breast: _____
- ☐ Body Contouring: _____

OTHER:

- ☐ Gallbladder: _____
- ☐ Appendix: _____
- ☐ OB/GYN: _____
- ☐ Sinus/Nose: _____
- ☐ Abdominal: _____
- ☐ Breast: _____

- ☐ Tonsils: _____
- ☐ Eyes: _____
- ☐ Heart: _____
- ☐ Orthopedic: _____
- ☐ Hysterectomy: _____
- ☐ Other: _____

Have you or anyone in your family had a reaction to general anesthesia? ☐ NO ☐ YES

If yes, please explain: _____

SCARRING, BLEEDING AND TRANSFUSIONS

Have you formed excessive or unsatisfactory scars in the past? ☐ NO ☐ YES

If yes, give locations: _____

Have you taken aspirin, anti-inflammatory medications or blood thinners within the past two weeks? ☐ NO ☐ YES

If yes, please list: _____

Have you had any prolonged bleeding when cut and/or is it in your family history? ☐ NO ☐ YES

Have you had a blood transfusion? ☐ NO ☐ YES *If yes, give date(s):* _____

Have you experienced a reaction to a transfusion? ☐ NO ☐ YES *If yes, please describe:* _____

_____

ALLERGIES

Medication(s) and type of reaction: _____

_____

Tape/Type: _____ *Soap(s):* _____

Food(s): _____

PERSONAL HEALTH HABITS

Do you now smoke, or have you ever smoked? ☐ NO ☐ YES *If yes, how many packs per day?* _____

Have you quit? ☐ NO ☐ YES *If yes, when?* _____

Do you drink alcohol? ☐ NO ☐ YES *If yes, how often?* _____

Do you use any non-prescription medications or drugs not already listed? ☐ NO ☐ YES *If yes, please list:* _____

_____

Do you use any diet medicines? ☐ NO ☐ YES *If yes, please list:* _____

Do you use St. John's Wort? ☐ NO ☐ YES *If yes, please list the dosage and times you take it:* _____

Do you take Ginseng? ☐ NO ☐ YES *If yes, please list the dosage and times you take it:* _____

Do you take Omega 3 supplements? ☐ NO ☐ YES *If yes, please list the dosage and times you take it:* _____

Do you take any other herbal medications? ☐ NO ☐ YES *If yes, please list:* _____

_____

Completed by: _____

Reviewed with patient by/Physician's signature: _____ Date: _____