

SALMA MAZHAR M.D. P.A.
PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **Today's Date:** _____

Chief Complaint: (Briefly describe your main reason for coming to the doctor today)

Known Medical Problems: _____

Childhood Illnesses: _____

Previous Surgeries: (include dates) _____

Social History:

Do you smoke or did you smoke? Y ___ N ___ How much _____ How long _____

Do you drink alcoholic beverages? Y ___ N ___ How often _____

Do you do or did drugs? Y ___ N ___ what, when and route _____

Do you drink coffee/tea/sodas? Y ___ N ___ How much _____

Do you follow a particular diet? Y ___ N ___ If so what _____

Do you exercise regularly? Y ___ N ___ What kind _____ How much _____

What kind of work you do now? _____

What kind of work have you done before? _____

Are you aware of any hazardous exposures associated with your present or past employment? Y ___ N ___

If yes, what _____

Have you served in military? Y ___ N ___

Have you received workman comp or other disability? Y ___ N ___

What is the highest level of education you have had _____

Where were you born? _____ Where else you have lived? _____

Family History :(please list any family member with major health problems and specify the problem).

Father: _____ Mother: _____

Brothers/Sisters: _____

Others: _____

Allergies: _____ **Reaction** _____

Current Medications taken: _____

Screening Tests: (List the date and place where done as applicable to you)

Last Pap smear: _____ Last Mammo: _____

Last Colonoscopy: _____ Last PSA: _____

Last Bone density scan: _____

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Review of Systems: (Please check any of the problems below that you have now or have had recently.)

- | | |
|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Vaginal discharge/menstrual problems |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Breast pain/lumps |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Painful testicles |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Change in mole |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Desire psychiatric help |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Work or family problem |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Excessive worry, anxiety |
| <input type="checkbox"/> Weight loss | |
| <input type="checkbox"/> Eye problems | |
| <input type="checkbox"/> Hearing trouble/Ear problems | |
| <input type="checkbox"/> Sinus trouble | |
| <input type="checkbox"/> Gum problems | |
| <input type="checkbox"/> Persistent hoarseness | |
| <input type="checkbox"/> Frequent cough | |
| <input type="checkbox"/> Coughing up blood | |
| <input type="checkbox"/> Difficulty breathing | |
| <input type="checkbox"/> Chest pain/tightness/pressure | |
| <input type="checkbox"/> Heart racing | |
| <input type="checkbox"/> Swelling of legs, feet or hands etc | |
| <input type="checkbox"/> Difficulty swallowing | |
| <input type="checkbox"/> Nausea | |
| <input type="checkbox"/> Vomiting | |
| <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Black stools | |
| <input type="checkbox"/> Blood in stools | |
| <input type="checkbox"/> Heartburn, gas, belching, bloating | |
| <input type="checkbox"/> Burning on urination | |
| <input type="checkbox"/> Blood in urine | |
| <input type="checkbox"/> Frequent Urination | |
| <input type="checkbox"/> Getting up several times at night to urinate | |
| <input type="checkbox"/> Vaginal discharge? Menstrual problems | |
| <input type="checkbox"/> Breast pain/lump | |
| <input type="checkbox"/> Take birth control pills | |
| <input type="checkbox"/> Take hormone replacement therapy | |
| <input type="checkbox"/> Joint pain, swelling, stiffness | |
| <input type="checkbox"/> Muscle pain, weakness | |
| <input type="checkbox"/> Frequent or severe headaches | |
| <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Blackout spells | |
| <input type="checkbox"/> Numbness or tingling | |
| <input type="checkbox"/> Trembling, shaking | |
| <input type="checkbox"/> Loss of memory or concentration | |
| <input type="checkbox"/> Depression, crying spells | |