Patient Health Questionnaire and History

Patient Name:_____ Date:_____

Height:_____ Weight:_____ Unusual weight gain/loss? Yes No

1. Do you now have or have previously had any of the following conditions?

*Pacemaker	Yes No	*Cardiovascular Disease	Yes No
Alzheimer's	Yes No	Cauda Equina Syndrome	Yes No
Cerebral Vascular Accident	Yes No	Current Infection	Yes No
Diabetes Mellitus Type 1 or 2	Yes No	Fibromyalgia	Yes No
Fracture or Suspected Fracture	Yes No	High Blood Pressure	Yes No
*History of Cancer	Yes No	Lupus	Yes No
Muscular Dystrophy	Yes No	Obesity	Yes No
Osteoarthritis	Yes No	Parkinson's	Yes No
Rheumatoid Arthritis	Yes No	Traumatic Brain Injury	Yes No
*Pregnant (currently)	Yes No	Metal	Yes No
How many weeks?_____		Joint replacement, spinal fusion, plates/screws:_____	

2. List any orthopedic surgeries and dates:_____
_____
_____

3. Have you ever taken steroids or blood thinners for an extended period of time? Yes No

4. List all medications you are now taking **(* Note: You may provide a list of all medications on your next visit):**_____
_____
_____
_____