



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

☐ Blood disorders (anemia, etc.)

☐ Kidney Problems

☐ Immune disorders

☐ Fainting or blackout episodes

☐ Thyroid problems

☐ Hepatitis

☐ Heart murmur

☐ High blood pressure

☐ Herpes, fever blisters

☐ Lung/respiratory problems

☐ Heart valve disorder

☐ Ulcer disease

☐ Skin disorders

☐ Shortness of breath

☐ Rheumatic Fever

☐ Heart disease and/or heart attack

☐ Eyes: burning, dryness, itching

☐ Swelling of ankles

☐ Irregular heart beat, palpitations

☐ Diabetes

☐ Cancer

Are you pregnant? ☐ NO ☐ YES

Date of last menstrual period: _____

How many pregnancies: _____

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

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 TRANSFUSIONSHave 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 ☐ YESHave 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: _____