

Patient Health Questionnaire

Name: _____ Birth date: ____/____/____ Age: _____

Medical History:

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Circulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinsons	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Describe any other conditions or precautions

Fall History (circle one):

Injury as a result of a fall in the past year? YES NO

Two or more falls in the last year? YES NO

Surgical History (body region and date):

Current Medications:
