CORNERSTONE CARE

Patient Health Questionnaire

Please note : This is a confidential part of our medical record and will be kept in the office
Information contained here will not be released to any person except when you have authorized us

Name : _____ Date : _____

DOB : _____ Age : _____

Pharmacy _____

Reason for visit _____

Previous PCP _____
(including address and phone number)

Previous Specialist(s) _____
(including address and phone number)

Medical Information

Medical Illnesses or Conditions (any chronic conditions which you have been diagnosed to have) : ☐ **NONE**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Mental Health Issues (have you ever been diagnosed to have anxiety , depression , or others) : ☐ **NONE**

_____ _____ _____

Medications (Include over the counter , herbal or natural remedies..) : ☐ **NONE**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient name : _____ DOB : _____ Date : _____

Allergies Are you allergic to any drugs ? (Circle) No Yes

If yes : Medicine : _____ Reaction Type : _____

Medicine : _____ Reaction Type : _____

Medicine : _____ Reaction Type : _____

Have you ever been diagnosed to have : (Check box by all that apply)

Cataract ☐
Glaucoma ☐

Migraine ☐
Stroke ☐
Seizures ☐

Seasonal Allergies ☐

Heart disease ☐
Heart attack or angina ☐
Heart murmur ☐
high blood pressure ☐

Pneumonia ☐
COPD/asthma ☐

Acid reflux ☐
Liver disease ☐
Colon polyps ☐
Stomach ulcers ☐

Kidney disease ☐
Kidney stone ☐

Diabetes ☐
Thyroid disease ☐

Depression ☐
Anxiety ☐

High cholesterol ☐

Anemia ☐
Bleeding disorders ☐

Cancer (type) : ☐

Enlarged prostate ☐
Urination problems ☐

Rheumatic fever ☐
Chicken pox ☐
Shingles ☐

NONE OF THE ABOVE : ☐

Operations ☐ **NONE**
Please list any surgery and approximate year

Year	**Surgery**
_____	_____
_____	_____
_____	_____

Hospitalizations ☐ **NONE**
(other than operations)

Year	**Reason**	**Hospital**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Patient name : _____ DOB : _____ Date : _____

Family Medical History **List significant illnesses :**

(Ex: Mental health , diabetes , high blood pressure , heart disease ,
stroke , seizures , lung problems , cancer , alcoholism, thyroid)

History	Age	Health	If deceased list age of death and reason
Father			
Mother			
Brothers			
Sisters			
Children			
Grandparents			
Other Relatives			

Health Maintanence Location : Hospital , institution….

Last Colonoscopy _____ _____

Last Pap smear _____ _____

Last Mammogram _____ _____

Immunizations	Year	**Immunizations**	Year
Tetanus (Tdap,Td)	_____	Hepatitis A	_____
Flu (influenza)	_____	Hepatitis B	_____
Pneumonia - Pneumovax (PPV23)	_____	Shingles	_____

Pneumonia - Prevnar (PCV13) _____ MMR _____
HPV (Gardisil) _____ (measles, mumps , rubella)
Other _____

Patient name : _____ DOB : _____ Date : _____

Social History

Marital status Single Married Divorced Widowed In a relationship

Do you exercise routinely NO YES (if yes , what exercise/how often) _____

Do you smoke (circle) Never Current Past stop date _____

Cigar Pipe Cigarettes If yes : #packs / day ___ #years : ____

Do you drink (circle)? caffeinated coffee / teas / or sodas No Yes #/day _____

Do you drink alcohol (circle) : Never Current Past stop date _____

_____ socially (less than once/week) drinks per outing 1 2 3 4
_____ Beer
_____ liquor other _____

Do you use recreational drugs (circle): Never Current Past stop date _____

Marijuana Heroin Cocaine other _____

Are you sexually active (circle) : Never Current Past

Males Females Both

Contraception method (circle):
condoms IUD Depo injection Nexplanon/Implanon Oral Contraceptives

Permanent Sterilization (vasectomy , tubal ligation…) _____

Other _____

Level of education _____

Occupation (if retired state previous occupation) : _____

If disabled , check here _____ Nature of disability _____

Do you have (please check): ☐ Advance directives ☐ Living Will

Are you under a lot of pressure/stress at home or work?

No Yes Clarification _____

PROVIDER REVIEWED _____

SIGNATURE _____

DATE _____