**Boston University**
**Neurology Associates**
*Patient Health Questionnaire*

**Name:**_____ **Age:**____ **Date of Birth:**____/____/____ **Languages Spoken:**_____

☐ Female
☐ Male

☐ Right-Handed
☐ Left-Handed

**Marital Status:**
☐ Single
☐ Married/Partnered
☐ Divorced
☐ Widowed

**Level of Education:**
☐ Grade 0-8
☐ High School
☐ Special Training
☐ College ☐ Grad +

**Current Work Status:**
☐ Student
☐ Homemaker
☐ Retired ☐ On Disability
☐ Working:

Please list any **ALLERGIES** and your **REACTION(S)**:
☐ None ☐ Seasonal (Pollens/Grasses/Molds...)

| *Drug/Food* | *Reaction* |
|---|---|
| | |
| | |
| | |
| | |

Please list all **MEDICAL PROBLEMS** for which you are currently being treated: ☐ None

List past **HOSPITALIZATIONS** and/or **SURGERIES**:
☐ None

| Date | Event |
|---|---|
| | |
| | |
| | |
| | |

List any significant CHILDOOD/YOUTH ILLNESSES:
☐ Only "usual" (e.g. Measles, chicken pox . . .)

List all **PRESCRIPTION** and **NON-PRESCRIPTION MEDICINES/SUPPLEMENTS/REMEDIES** you are taking:

| Medication Name | Dosage | How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Medication Name | Dosage | How Often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you use **TOBACCO**? ☐ No ☐ Yes
☐ *Cigarettes* _____Packs per day
☐ *Cigar/Pipe* _____Times per day
☐ *Chewing* _____Times per day
For how long?_____
Have you quite? ☐ No ☐ Yes
Tried to quit? ☐ No ☐ Yes

Do you drink **ALCOHOL**? ☐ No ☐ Yes
Beer..... ☐ Now & Then ☐ Weekly ☐ Daily
Wine.... ☐ Now & Then ☐ Weekly ☐ Daily
Liquor... ☐ Now & Then ☐ Weekly ☐ Daily
Did you drink alcohol in the past and then quit? ☐ No ☐ Yes

Do you drink **CAFFEINE-**containing drinks?
☐ No ☐ Yes
#_____per day

**Please check off any of the following that apply to you:**

| | | | |
|---|---|---|---|
| ☐ Dentures (Upper) | ☐ Cane | ☐ Glasses | ☐ Pacemaker |
| ☐ Dentures (Lower) | ☐ Walker | ☐ Contact Lenses | ☐ Implanted pump/devise |
| ☐ Partial Plate | ☐ Wheelchair | ☐ Hearing Aid | ☐ Artificial joint/hip/limb |
| ☐ Loose Teeth | ☐ Motorized Cart | | ☐ Implanted metal pins/plate |

Do you **DRIVE**? ☐ No ☐ Yes
Do you require specially-arranged transportation?
☐ No ☐ Yes

Do you currently receive assistance in the home from:
**Family/Friends?** ☐ No ☐ Yes
**Agencies? (VNA)** ☐ No ☐ Yes

When did you last visit your . . .
**Primary Care MD**?____/____
**Dentist**? ____/____
**OB/GYN**? ____/____

**DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE HEALTH PROBLEMS LISTED BELOW?**
**Please circle** *Yes* **or** *No* *-Review of Systems-*

**CARDIAC PROBLEMS**
**YES/NO** Heart Attack/Mi
**YES/NO** Chest Pain/Angina
**YES/NO** Heart Failure/CHF
**YES/NO** Irregular Heart Beat
**YES/NO** Fainting/Syncope
**YES/NO** Heart Murmur
**YES/NO** Rheumatic Fever
**YES/NO** High Blood Pressure
**YES/NO** Other, _____

**RESPIRATORY PROBLEMS**
**YES/NO** Chronic Cough
**YES/NO** Asthma
**YES/NO** Bronchitis
**YES/NO** Emphysema
**YES/NO** Pneumonia
**YES/NO** Tuberculosis
**YES/NO** Lung Cancer
**YES/NO** Other,
_____

**GASTROINTESTINAL PROBLEMS**
**YES/NO** Difficulty Swallow./Chew.
**YES/NO** Ulcer (Peptic, "Bleeding"...)
**YES/NO** Jaundice/Hepatitis
**YES/NO** Heart Burn/Reflux
**YES/NO** Inflammatory Bowel Dis.
**YES/NO** Bowel Control Problems
**YES/NO** Hiatus Hernia
**YES/NO** Chronic Diarrhea/Constip.
**YES/NO** Other, _____

**MUSCULOSKELETAL PROBLEMS**
**YES/NO** Arthritis
**YES/NO** Gout
**YES/NO** Osteoporosis
**YES/NO** Muscle strain/pulls
**YES/NO** Congenital deformities
**YES/NO** Other, _____

**DERMATOLOGICAL PROBLEMS**
**YES/NO** Dermatitis
**YES/NO** Rashes
**YES/NO** "Shingles
**YES/NO** Excema
**YES/NO** Skin Cancer
**YES/NO** Herpes
**YES/NO** Severe Itching
**YES/NO** Severe Acne
**YES/NO** Other, _____

**BLOOD/BLEEDING PROBLEMS**
**YES/NO** Anemia
**YES/NO** Sickle Cell
**YES/NO** Hemophilia
**YES/NO** Other, _____
**YES/NO** Easy Brusing

**UROLOGICAL PROBLEMS**
**YES/NO** Frequent Urination
**YES/NO** Difficult Urination
**YES/NO** Kidney Stones
**YES/NO** Other, _____
**YES/NO** Incontinence/Bladder Control problems
**YES/NO** Frequent Urinary Tract Infections

**REPRODUCTIVE SYSTEM PROBLEMS**
**YES/NO** Difficult/Irregular Menstruation
**YES/NO** Difficult/Problem Pregnancy
**YES/NO** Sexually-transmitted Diseases
**YES/NO** Other, _____
**YES/NO** Fertility Problems
**YES/NO** Cancer (Ovarian, Testicular, Uterine or Prostate)

**BRIEF FAMILY HISTORY**
MOTHER: ☐ Alive ☐ Deceased, Cause of Death: _____
Does/Did she have any illnesses listed on this page? _____

FATHER: ☐ Alive ☐ Deceased, Cause of Death: _____
Does/Did he have any illnesses listed on this page? _____
Any other family history of illnesses listed on this page?
_____
CHILDREN: #_____ Male #_____ Female Do they have any health problems? _____
_____
_____

**ENDOCRINE PROBLEMS**
**YES/NO** Diabetes
if Yes, How Long?
Insulin user? **YES/NO**
**YES/NO** Thyroid Problems
**YES/NO** Other, _____

**NEUROLOGICAL PROBLEMS**
**YES/NO** Dizzy Spells
**YES/NO** Tremor
**YES/NO** Headache
**YES/NO** Stroke/CVA
**YES/NO** Chronic Pain
**YES/NO** Insomnia
**YES/NO** Multiple Sclerosis
**YES/NO** Myasthenia Gravis
**YES/NO** Parkinson's Dis.
**YES/NO** Huntington's Dis.
**YES/NO** Head Injury
**YES/NO** Seizures/Epilepsy
**YES/NO** Memory Problems
**YES/NO** Other, _____

**PSYCHOLOGICAL PROBLEMS**
**YES/NO** Anxiety Attacks
**YES/NO** Depression
**YES/NO** Eating Disorder
**YES/NO** Addiction
**YES/NO** Hullucinations
**YES/NO** Difficulty Concentrating
**YES/NO** Other,
_____

**Do you have a Health Care Proxy? YES/NO**
_____
**Name of Proxy**

| **Patient Sign** **Date** | **Informant (if not patient)** **Date** | **MD or RN Sign** **Date** |
|---|---|---|