RUSH

Rush Copley Medical Group

Patient Health Questionnaire

IDN13150147

ALL FIELDS MUST BE COMPLETED

NEW PATIENT HISTORY FORM

Date of Visit: _____

Name:	**Date of Birth:**	❑ Male ❑ Female ❑ Right-handed ❑ Left-handed
Primary Care Doctor (Name, Address, Phone #)**:**		
Referring Doctor (Name, Address, Phone #)**:**		
Other Doctors Involved in Your Care (Name and Specialty)**:** **1.**		
2.		

PRESENT PROBLEM

What is your primary complaint?
When did it begin?
What caused it?
What makes it better?
What makes it worse?
Any related symptoms?
What treatments have you tried and for how long?
Is this a work-related problem? Date of accident?
Anything else we should know?

MEDICAL HISTORY

Medical Problems (e.g. diabetes, hypertension)

Surgeries (please include year and hospital)

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Medications and Doses (e.g. Aspirin 81 mg daily)	**Allergies and Reactions** (e.g. Penicillin – rash)
❑ List attached	❑ No known allergies

REVIEW OF SYSTEMS

(Please only check the problems you are **currently** experiencing)

Constitutional: ❑ Fever ❑ Night sweats ❑ Weight gain ❑ Weight loss	**Cardiovascular:** ❑ Chest pain ❑ Palpitations	**Respiratory:** ❑ Shortness of breath ❑ Wheezing ❑ Coughing up blood	**Gastrointestinal** ❑ Blood in stool ❑ Nausea/vomiting ❑ Diarrhea ❑ Constipation
Genitourinary: ❑ Poor control of bladder ❑ Burning with urination ❑ Sexual dysfunction	**Musculoskeletal:** ❑ Neck pain ❑ Back pain ❑ Loss of muscle bulk ❑ Muscle spasms	**Psychosocial:** ❑ Depression ❑ Anxiety ❑ Mood swings ❑ Hallucinations	**Hematologic:** ❑ Easy bruising or bleeding ❑ Frequent nose bleeds ❑ Lymph node swelling
Skin and Breast: ❑ Body rash or hives ❑ Discharge from nipples ❑ Problems with wound healing	**Endocrine:** ❑ Cold intolerance ❑ Heat intolerance ❑ Excessive thirst ❑ Excessive urination	**Neurologic:** ❑ Poor/double vision ❑ Loss of hearing ❑ Headaches ❑ Speech difficulty	**Other:** ❑ ❑ ❑ ❑

FAMILY HISTORY

	Alive?	**Age**	**Significant Health Problems**		**Age**	**Significant Health Problems**
Mother				**Children**		
Father						
Siblings						

SOCIAL HISTORY

Education (highest level): ❑ Less than high school ❑ Some high school ❑ High school diploma ❑ Some college ❑ College degree ❑ Post-college degree	**Marital Status:** ❑ Single ❑ Married ❑ Widow(er) ❑ Divorced	**Work Status:** ❑ Occupation: _____ ❑ Working full-time ❑ Working part-time ____ hours/week ❑ Retired for ____ years ❑ Disabled for ____ years
Tobacco: ❑ Currently smoke _____ packs/day for _____ years ❑ Quit smoking _____ years ago ❑ Never smoked ❑ Use/used smokeless tobacco (e.g. snuff or chew): _____	**Alcohol:** ❑ Currently drink _____ alcoholic drinks per week ❑ Quit drinking _____ years ago ❑ Never drank alcohol	**Drugs:** ❑ Currently use recreational/street drugs (cocaine, marijuana, LSD, heroin, etc.) ❑ Quit using drugs _____ years ago ❑ Never used drugs

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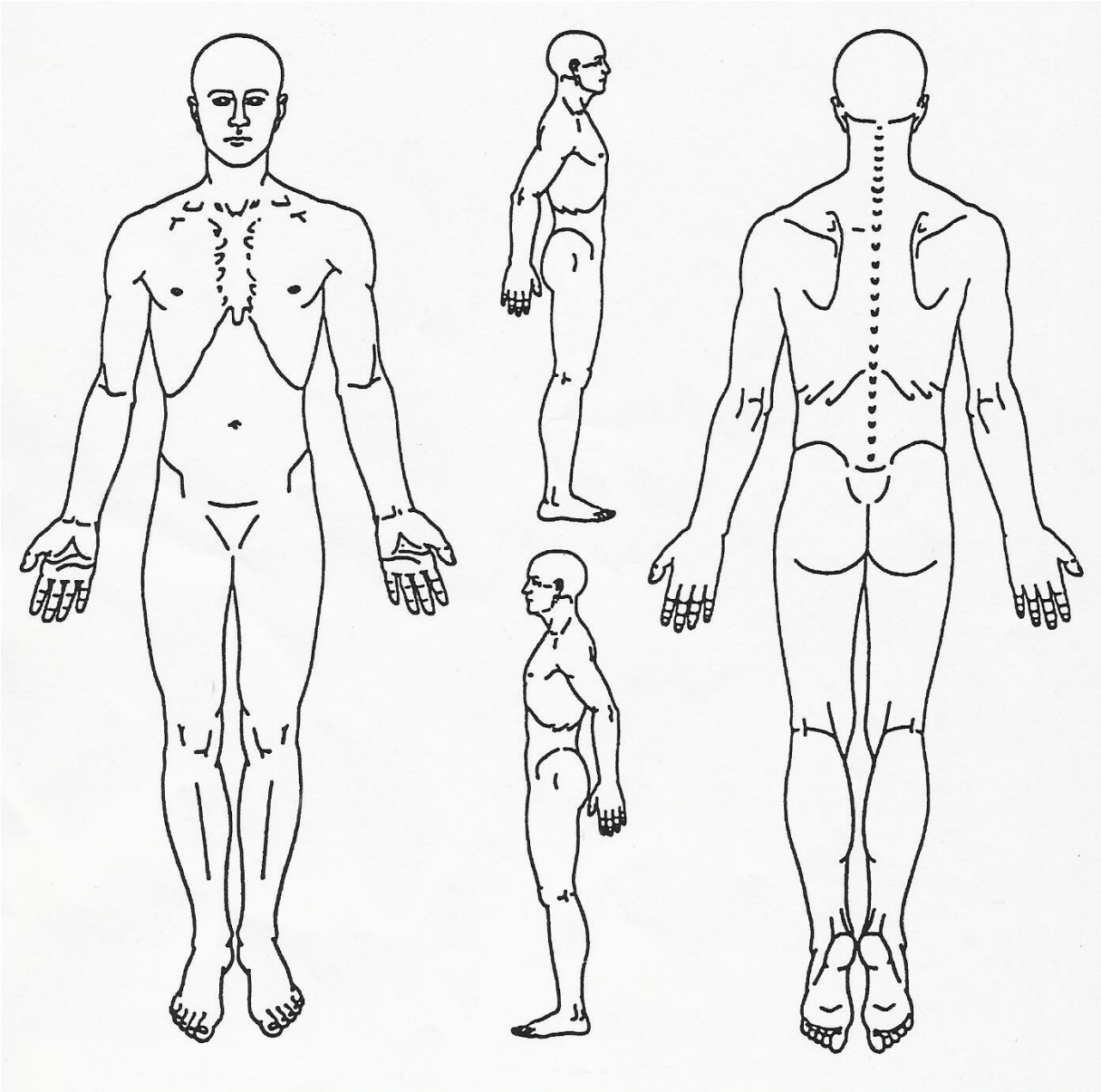
PAIN DIAGRAM

1. On the pictures below, please mark with "x" where you are experiencing pain and with "o" where you are experiencing numbness:

Pain: xxxxxxxxxxxx **Numbness: ooooooooooo**



2. Please circle the number that best corresponds to how much <u>pain</u> you experience in each of these areas <u>on an average day</u> (0 = no pain, 10 = unbearable pain):

Neck:	0	1	2	3	4	5	6	7	8	9	10
Right arm:	0	1	2	3	4	5	6	7	8	9	10
Left arm:	0	1	2	3	4	5	6	7	8	9	10

Back:	0	1	2	3	4	5	6	7	8	9	10
Right leg:	0	1	2	3	4	5	6	7	8	9	10
Left leg:	0	1	2	3	4	5	6	7	8	9	10