THE STELLA CENTER
509 Olive Way, Suite 1430
Seattle, WA. 98101

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Do you or have you ever had the following:

	Yes	No		Yes	No		Yes	No
Asthma/Emphysema	☐	☐	Diabetes	☐	☐	Polio/Paralysis	☐	☐
Shortness of breath	☐	☐	Thyroid disease	☐	☐	Back pain/injury	☐	☐
High blood pressure	☐	☐	Tuberculosis	☐	☐	Numbness of arms /legs	☐	☐
Chest pain	☐	☐	Lung disease /trouble	☐	☐	Anemia	☐	☐
Irregular heart beats	☐	☐	Heart failure	☐	☐	Sickle cell illness	☐	☐
Stroke(s)	☐	☐	Heart attacks	☐	☐	Low blood sugar	☐	☐
Seizure/Epilepsy	☐	☐	Rheumatic fever	☐	☐	Heartburn/ Esophageal reflux	☐	☐
Easy bleeding/bruising	☐	☐	Heart murmur	☐	☐	Other: _____		
HIV	☐	☐	Fainting/Blackouts	☐	☐	_____		
Liver disease/Hepatitis	☐	☐						

Are you or could you be pregnant? ☐ Yes ☐ No

Would you agree to a blood transfusion in a life-threatening case? ☐ Yes ☐ No

Do you currently use: Eyeglasses ☐ Yes ☐ No Contact lenses ☐ Yes ☐ No
Hearing aid(s) ☐ Yes ☐ No Dentures ☐ Yes ☐ No

Have you had any previous surgeries? Please describe: _____

_____

Are you allergic to any drugs or medications? Please describe: _____

Are you currently taking any medications? Please describe:_____

Do you take aspirin or anticoagulants? ☐ Yes ☐ No

List all genetic disorders/family medical problems:_____

Social history:

☐ Never smoked ☐ Former smoker – Time since quitting: _____ ☐ Currently smoke ___ packs/ day for ___ years

Alcohol consumption: _____ Caffeine consumption: _____

OFFICE USE ONLY

I personally reviewed this questionnaire:_____ Date:_____