PACIFIC PALISADES
Medical Group
CLINICAL AFFILIATE OF THE UCLA MEDICAL GROUP

Patient Health Questionaire
New Patient Comple Physical Exam (CPE)
Existing Patient (CPE)
Update = 6/25/04

PLEASE COMPLETE PRIOR TO YOUR PHYSICIAN VISIT

Name: **Date:** / /

Address:

Occupation:

Current Employer:

Previous primary physician:

Current Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Single

Number of Children:_____

(Women Only)
_____ Number of pregnancies
_____ Number of live births
_____ Number of miscarraiges _____ Number of abortions

no	*yes*	
☐	☐	Do you have regular periods?

Date of your last regular period:_____/_____/_____

Smoking Status:
- ☐ Never smoked
- ☐ Smoked and stopped ____years ago
- ☐ Currently smoke _____ cigarettes/day

Approximate number of alcohol drinks consumed per week:
- ☐ None ☐ 7-14
- ☐ <7 ☐ >14

no	*yes*	
☐	☐	Do you use recreational drugs?
☐	☐	Any history of alcohol problems?

Describe your weekly exercise regimen:

List the following:

Prior hospitalizations and surguries with the dates and diagnosis:

Current regular medications and dosage:

Past serious illnesses or current problems for which you are under treatment:

Current "as needed" medications and dosage:

Medication Allergies:

List other physicians from which you receive care and the condition(s):

Sexual preference:
- ☐ Heterosexual
- ☐ Men with men
- ☐ Women with women

Number of sexual partners in last year:_____
Form of contraception:_____

no	*yes*	
☐	☐	Do you always wear a seat belt?
☐	☐	Do you have guns in your home?

If you have had any of the following procedures or test, list the last date and results:

Physical exam	
Colonoscopy	
Cardiac Stress Test	
Mammogram	
Pap smear	
Bone Density	
Pneumonia Vaccine	
Diptheria Tetnaus Shot	

Do you have any of the following problems?

	no	*yes*	*(Please mark a response to each item)*
1	☐	☐	A change in your usual headache pattern
2	☐	☐	Difficulty hearing
3	☐	☐	Recent sudden vision changes
4	☐	☐	Pain with swallowing food or liquid
5	☐	☐	Chest pain with exertion
6	☐	☐	Chest pain at rest
7	☐	☐	Shortness of breath at low exercise levels
8	☐	☐	Chronic cough
9	☐	☐	Unexplained loss of consciousness
10	☐	☐	Unexplained weight loss
11	☐	☐	Night sweats
12	☐	☐	Abdominal pain
13	☐	☐	Blood in your stools or black stools
14	☐	☐	Difficulty with urination on a regular basis
15	☐	☐	Blood in your urine
16	☐	☐	Trouble with sexual function
17	☐	☐	Significant joint pain
18	☐	☐	Loss of interest in daily activities or low self esteem or feelings of hopelessness
19	☐	☐	Severe problems with sleep
20	☐	☐	Skin lesions that will not heal
21	☐	☐	Unexplained weakness in any extremity
22	☐	☐	Loss of balance or coordination
23	☐	☐	Irregular menstrual bleeding (women only)
24	☐	☐	Vaginal bleeding after menopause (women only)
25	☐	☐	Are you dissatisfied with your present weight?

Describe positive answers:

Have any first degree relatives (mother, father, sister, brother) had any of the following conditions?

	no	*yes*	*(Please mark a response to each item)*
1	☐	☐	Colon cancer before age 60
2	☐	☐	Melanoma skin cancer
3	☐	☐	Prostate cancer before age 70
4	☐	☐	Breast cancer
5	☐	☐	Uterine cancer
6	☐	☐	Ovarian cancer
7	☐	☐	Angina or heart attack before age 60
8	☐	☐	High blood pressure
9	☐	☐	Diabetes

Describe positive answers:

Reviewed by: