Patient Health Questionnaire and History

1. Have you ever had? (If yes, please explain)
    - High blood pressure Y/ N________________________________
    - Heart or circulation Disorders Y/ N________________________________
    - Seizures Y/ N________________________________
    - Dizzy spells Y/ N________________________________
    - Diabetes Y/ N________________________________
    - Cancer Y/ N________________________________
    - Arthritis Y/ N________________________________
    - Immune deficiency disease Y/N________________________________
    - Leakage of bladder or bowel Y/ N________________________________
    - Frequent urination Y/ N________________________________
    - Painful intercourse Y/ N________________________________
    - Depression Y/ N________________________________
    - Headaches Y/ N________________________________
    - Other Y/ N________________________________

2. Please list any surgeries you have had along with procedure and dates:

    ____

3. Do you have any METAL anywhere in your body (pins/ plates/ pacemaker) other than teeth?

    Y/ N Describe:____

4. For women only: Are you now pregnant? Y/ N If yes, how many weeks pregnant?__________

    Are you post menopausal? Y/ N If yes, date of last period?__________________________

5. Do you have any abnormal trouble with vision? Y/ N Hearing? Y/ N
6. List all allergies you may have:____
7. Have you ever taken steroids or anti coagulants for an extended period of time? Y/ N
8. Have you had any unusual weight gain or loss? Y/ N
9. List all medications you are now taking:______________________________________