T.T.CHANNAPATI, MD AND ASSOCIATES
PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME_________________________________AGE________________VISIT DATE__________

ARE YOU ALLERGIC TO LATEX __YES __ NO   ANY MEDICATIONS ___YES __NO. IF YES PLEASE LIST:

DO YOU TAKE ANY PRESCRIPTION MEDICATIONS REGULARLY? ___YES ___NO.   IF YES PLEASE LIST:

DO YOU USE ANY TOBACCO PRODUCTS? ___YES ___NO. HOW LONG ______ HOW MUCH PER DAY______ QUIT HOW MANY YEARS AGO_____________
DO YOU USE ALCOHOL? ___YES ____NO. HOW LONG _______ HOW MUCH PER DAY ______ QUIT HOW MANY YEARS AGO ___________________.

DO YOU SUFFER FROM ANY OF THE FOLLOWING PROBLEMS? (CHECK FOR YES ONLY)

__Rheumatic Fever	__Diabetes	__bleeding disorder
__Hepatitis	__Hypertension	__Chest Pain
__Heart Disease	__Asthma	__Glaucoma
__Lung Disease	__Heart Attack	__Epilepsy/seizures
__Kidney problems	__Osteoporosis	__Hearing Loss
__Thyroid Disease	__Migraines	__Psychiatric Disorder
__Cancer	__Shortness of breath	__Depression

Please list if any of your siblings, children or parents suffers from any of the above conditions.

FAMILY MEMBER	LIVING OR DECEASED	PRESENT AGE OR AGE OF DEATH	ILLNESS OR CAUSE DEATH
FATHER			
MOTHER			
BROTHER/SISTER			
M or F			
M or F			
M or F			
SPOUSE			
SON/DAUGHTER			
M or F			
M or F			
M or F			

PAST HOSPITALIZATIONS:____

PAST SURGERIES:____