EVJC
EAST VALLEY JOINT CLINIC

Patient Health Questionnaire

Pease fill out the following to the best of your ability

Do you have any allergies ? ☐ Yes ☐ No If Yes, please list:_____

Do you have any of the following:

AIDS / HIV	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Back Injury	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Bleeding Disorder	☐ Yes	☐ No
Thyroid Problem	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Substance Abuse	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Pace Maker	☐ Yes	☐ No	COPD	☐ Yes	☐ No

Do any of your parents or grandparents have any of the above? Please specify:

_____

_____

_____

Please fill out entirely:

Advanced Directive	☐ Yes	☐ No	Live Alone	☐ Yes	☐ No
Use Alcohol	☐ Yes	☐ No	Married	☐ Yes	☐ No
Employed	☐ Yes	☐ No	Medical Power of Attorney	☐ Yes	☐ No
Tobacco Use	☐ Yes	☐ No	Transportation Difficulties	☐ Yes	☐ No
Able to care for self	☐ Yes	☐ No	Difficulty doing errands alone	☐ Yes	☐ No
Auto related	☐ Yes	☐ No	Difficulty dressing or bathing	☐ Yes	☐ No
Difficult walking or Climbing stairs	☐ Yes	☐ No	Hard of hearing	☐ Yes	☐ No
Daily Exercise	☐ Yes	☐ No			

Past Surgeries (please include year)

_____

_____

_____

Name: _____ Date:_____