PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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SUDIPTA AND BINDU DEY MD, INC.
127 PINES BRIDGE ROAD
BEACON FALLS, CT 06403

PATIENT INFORMATION SHEET

NAME:_____ DOB:_____ DATE _____

ALLERGIES:_____

SOCIAL HISTORY:

Recreational Drug Use:	Never	Past	Current
Smoking:	Never	Past	Current - Packs/Day:_____
Alcohol :	Never	Past	Current - Drinks/Day:_____

List ALL MEDICATIONS you take, including over the counter (OTC) medications and vitamins. Include specific doeses and when taken, If you don't know, please call your pharmacist to confirm.

Medications	OTC and Vitamins
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD	High Cholesterol	Psoriasis
Alcoholism	Dementia	HIV	Sciatica
Allergies, Seasonal	Depression	Hepatitis	Seizures
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stoke
Anxiety	Diverticulitis	Kidney Stones	Sleep Apnea
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Kidney Disease	Thyorid Disorder
Arthritis	Eczema	Lupus	Ulcerative Colitis
Asthma	Emphysema	Liver Disease	
Bipolar	Gallstones	Macular Degeneration	
Bladder problems /incontinence	GERD(Acid Reflux)	Migraines	
Bleeding problems	Glaucoma	Nosebleeds	
Cancer:_____	Heart Disease	Neuropathy	
Carpal Tunnel	Heart Attack (MI)	Osteopenia/Osteoporosis	
Headaches	Hiatal Hernia	Parkinson's Disease	
Crohn's Disease	High Blood Pressure	Peripheral Vascular Disease	

Other medical problems not listed above:

_____

Last Menstrual Period:	Yes / No	Date:_____	Normal / Abnormal
Mammogram:	Yes / No	Date:_____	Normal / Abnormal
Dxa (Bone Density)	Yes / No	Date:_____	Normal / Abnormal
Colonoscopy:	Yes / No	Date:_____	Normal / Abnormal

PATIENT INFORMATION SHEET
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Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____
_____ _____

Have you fallen in the last 6 months? Yes / No
If yes, please explain:

_____

FAMILY HISTORY: (Mother, Father, Siblings, Please indicate M/F or S next to the diagnosis)

Alcoholism	Breast Cancer	High Blood Pressure	Skin Cancer
Anemia	COPD/ Emphysema	High Cholesterol	Stroke
Arthritis	Colon Cancer	Kidney Disease	Thyroid Cancer
Asthma	Dementia	Lymph Cancer	Thyroid Disorder
Bipolar	Depression	Migraines	
Blood Cancer	Diabetes 1 or 2	Osteoporosis	
Blood Clot/DVT	Heart Disease	Prostate Cancer	

Other: _____

Do you have an Advanced Directive (Living Will)? Yes / No

List other medical providers you see on a regular basis (Cardiologist, Mental Health Provider, Kidney Doctor, etc...)

_____

_____

Patient Signature:_____ Date: _____

Provider Reviewed:_____ Date: _____