





Phone: (310) 623-4444 Fax: (310) 623-4455 [www.preventthepain.com](http://www.preventthepain.com)

**Patient Health Questionnaire Part 2:**

**11. What activities does your problem prevent you from doing?**

- Walking      Reaching      Bending      Dressing
- Grooming      Hygiene      Housekeeping      Driving
- Home Management

Other: \_\_\_\_\_

**12. What medical equipment do you have at home?**

- Walker      Wheelchair      Hospital Bed
- Commode      Shower Equipment

**13. What is your current living situation?**

- Live alone      Live with a caretaker      Live with a family member

**14. Please list all medications and herbal supplements you are taking now**

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**15. Please list any allergies:**

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**16. Do you have any of the following medical conditions? (Check all that apply)**

- Diabetes Mellitus      High/Low Blood Pressure      Incontinence      Defibrillator Implant
- Open Wounds      History of Seizures      Psychiatric History      Radiation or Chemotherapy
- Osteoporosis      Cancer or history of cancer      Urinary Tract Infection      Heart Disease/Hardening Arteries
- Sensory Deficits      Immune System Compromise      Respiratory Disease      Arthritis
- Lymphedema/Lymphedema Treatments      Pacemaker      Neurological Disorder

Other: \_\_\_\_\_

Past Surgeries/Approximate Year: \_\_\_\_\_

**17. Answer the following statements by checking yes or no. Have you had:**

Yes      No

- An unexplained weight loss of greater than 10 lbs in the past month?
- Numbness in both hands and/or both feet at the same time?
- Any changes in your bowel or bladder habits?
- Any numbness in your backside, in the area where you would sit on a bicycle seat?
- In coordination or weakness with walking?
- Any loss of balance or recent falls?