



## PHYSICAL EXAM QUESTIONNAIRE

NAME: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical concerns to address today, if any: <b>(Please note your insurance may require an additional copy)</b>			
<b>1. Tobacco use?</b>	<input type="checkbox"/> Non-User <input type="checkbox"/> Former User	<input type="checkbox"/> Second-hand exposure	<input type="checkbox"/> Current User <input type="checkbox"/> I want info on ___ Packs/day    quitting
<b>2. Alcohol use?</b>	<input type="checkbox"/> Non-User <input type="checkbox"/> Former User	<input type="checkbox"/> Current User, type: <input type="checkbox"/> Daily <input type="checkbox"/> Socially <input type="checkbox"/> Rarely <input type="checkbox"/> Other: _____ <input type="checkbox"/> I want info on quitting	
<b>3. Recreational Drug Use?</b>	<input type="checkbox"/> Non-User <input type="checkbox"/> Former User	<input type="checkbox"/> Current User, please describe use (optional) _____ <input type="checkbox"/> I want info on quitting	
<b>4. HIV Screening?</b>	<input type="checkbox"/> I would like to be screened today	<input type="checkbox"/> Screen completed: At: _____	<input type="checkbox"/> I do not wish to be screened
<b>5. (FEMALES AGE 16-25) Chlamydia Screening?</b>	<input type="checkbox"/> I would like to be screened today	<input type="checkbox"/> Screen completed: At: _____	<input type="checkbox"/> I do not wish to be screened
<b>6. Please date the following (if applicable):</b>	PAP:	Hysterectomy:	Mammogram:
	LMP:	DEXA Scan:	Colonoscopy:
<b>7. If you have DIABETES, select what is being completed at home</b>	<input type="checkbox"/> Glucose Checks <input type="checkbox"/> BP Checks <input type="checkbox"/> Foot Care <input type="checkbox"/> Regular Exercise	<input type="checkbox"/> Diet Management <input type="checkbox"/> I would like more info/assistance with my diabetes.	<b>Date of last:</b> Foot Exam: _____ Glucose: _____ A1C: _____
<b>8. If you have HIGH BLOOD PRESSURE, select what is being completed at home</b>	<input type="checkbox"/> BP Checks <input type="checkbox"/> Regular Exercise <input type="checkbox"/> Diet Management	<input type="checkbox"/> I would like more info/assistance with my high blood pressure.	
<b>9. Do you have difficulty with any of the following?  (Circle any that apply)</b>	Affording Groceries Paying Utilities Child Care Affording Doctor Visits		Affording Medications Transportation to Appointments Reading Healthcare Material Safety at Home
	If you selected any of the above, would you like assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		Are any of your needs URGENT? i.e. "I don't have food today." <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
<b>10. (Age 50+) Do you have any Advanced Directives?</b>	<input type="checkbox"/> None	<input type="checkbox"/> Living Will <input type="checkbox"/> Durable POA	<input type="checkbox"/> Healthcare Proxy <input type="checkbox"/> Want info? <input type="checkbox"/> YES <input type="checkbox"/> NO



## DEPRESSION SCREENING (PHQ-2/PHQ-9)

NAME: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Over the last **2 WEEKS**, how often have you been bothered by any of the following problems? **(Circle response)**

	Not at all (0 days)	Several days (3-7 days)	More than half of the days (8-10 days)	Nearly every day (11-14 days)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
<b>If you selected "0" to #1-2, you are complete and may sign at the bottom of the page. If you selected anything other than "0", please complete the questions below then sign.</b>				
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 or watching TV	0	1	2	3
8. Moving or speaking so slowly or quickly that other people noticed.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+ +		
	<b>TOTAL</b>			

<p>In the past year, have you had serious thoughts of suicide?</p> <p style="text-align: center;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</p> <p>Have you EVER attempted?</p> <p style="text-align: center;"><input type="checkbox"/> YES   <input type="checkbox"/> NO</p>	<p><b>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?</b></p>	<p><input type="checkbox"/> Not difficult at all</p> <p><input type="checkbox"/> Somewhat difficult</p> <p><input type="checkbox"/> Very difficult</p> <p><input type="checkbox"/> Extremely difficult</p>
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Patent Signature: \_\_\_\_\_

Provider to Initial: \_\_\_\_\_



## ANXIETY SCREENING (GAD-2/GAD-7)

NAME: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Over the last **2 WEEKS**, how often have you been bothered by any of the following problems? **(Circle response)**

	Not at all (0 days)	Several days (1-7 days)	More than half of the days (8-10 days)	Nearly every day (11-14 days)
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
<b>If you selected "0" to #1-2, you are complete and may sign at the bottom of the page.            If you selected anything other than "0", please complete the questions below then sign.</b>				
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	add columns	+                    +		
	<b>TOTAL</b>			

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

Patent Signature: \_\_\_\_\_

Provider to Initial: \_\_\_\_\_