COMMUNITY CARE PHYSICIANS
Division of Family Care
Our Family Caring for Your Family

PHYSICAL EXAM QUESTIONNAIRE

NAME: _____

DOB: _____/_____/_____ **DATE:** _____/_____/_____

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

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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**
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.				
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	**+**	**+**	
	TOTAL			

In the past year, have you had serious thoughts of suicide? ☐ **YES** ☐**NO** Have you EVER attempted? ☐ **YES** ☐**NO**	**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:** _____

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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**
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.				
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	**+**	**+**	
	TOTAL			

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:** _____