COMMUNITY CARE PHYSICIANS

Dear Community Care Patient,

Current guidelines for preventive health services recommend screening for certain personal risk factors that may be associated with a person's lifestyle. Please take a few moments to answer these questions, which will help us to complete your overall health assessment. As with all of your personal health information, your answers will be strictly confidential.

Patient Name _____ Date of Birth _____

Date of Visit _____

Directions: Please place an **"x"** in the box that represents your answer to each question

For patients 18 years of age and older	**YES**	**NO**
Do you smoke a pipe, cigarettes, or cigars or use chewing tobacco?		
Have you fallen in the past year?		
Do you feel unsteady or worry about falling?		
Do you ever feel unsafe at home?		
Are you in a relationship in which you have been physically hurt 01· felt threatened?		
-Have you had more than one sexual partner within the last six months?		
Do you follow a special diet?		
Do you exercise at least three times a week for twenty minutes or more?		
Do you have an Advanced Directive (Living Will, DNR, or HealthCare Proxy)?		

Answering the following questions will help us determine if you are due for certain health maintenance · and/or screening tests. Where applicable, please indicate the approximate date of when you last received the service listed below:

For patients age 50 and over:	Approximate date of last colonoscopy:
For all women:	Approximate date of last PAP test·:
For women age 40 and over:	Approximate date of last mammogram:
For patients with Diabetes **and** all patients age 65 and over:	Approximate date of last eye doctor visit:
	Eye doctor's name:
For women age 65 and over:	Approximate date of last bone density scan:
	Location:
For all patients:	Discuss your individual risk factors with your doctor to see if additional screening or screening at an earlier age is needed.

Thank you for your responses.

Patient Name: _____ DOB: _____ Date: ___/___/_____

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 asleep, 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're 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 fidgety 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 in some way	0	1	2	3

Column Totals: _____ + _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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

Form completed by:
☐ Patient
☐ Provider
☐ Other Staff: _____
(Name)

Reviewed by: _____
(Provider Signature)

Revised 4.11.17

Name (Please Print)_____DOB:_____Date: _____

Alcohol screening questionnaire (AUDIT) + 1 Question Drug Use

We ask all patients about alcohol and drug use at least once a year. Both can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	None	***1 or More***
How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"	○	○

For Office Use Only: Total Score: _____

PCP Initials: _____

COMMUNITY CARE PHYSICIANS

Date:

Patient DOB:

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		YES / NO
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	Y N
$	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Are you **afraid you might be hurt** in your apartment building or house?	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N