Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Screening Questionnaire**

Please answer the following questions to the best of your knowledge.

**Depression Screening**

Patients 12 years of age and older, please circle yes or no. In the last two weeks have you…

1. Little interest or pleasure in doing things? Not at all Several days Nearly every day
2. Feeling down, depressed, or hopeless? Not at all Several days Nearly every day

**Tobacco Screening**

Patients 18 years of age or older, please circle yes or no.

1. Former smoker? Yes No
2. Current smoker? Yes No

If you circled “yes” to current smoker, please answer the following questions.

1. When did you start smoking? ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How often do you smoke cigarettes? ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How many cigarettes a day do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How soon after you wake up do you smoke your first cigarette? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Are you interested in quitting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pneumonia Vaccination Status**

Patients 65 years of age or older, please answer the following questions.

1. When was your last pneumonia vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Where did you have your last pneumonia vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Colorectal Cancer Screening**

Patients 50-75 years of age, please answer the following questions.

1. Last colorectal screening (ex: colonoscopy, flexible sigmoidoscopy, cologuard, etc.)?

­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Performing physician’s name and facility?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN ONLY: Cervical Cancer Screening (21-64 years) and Breast Cancer Screening (50-74 years)**

1. Date of last pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Results of last pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Date of last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Results of last mammogram? ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete questions on page 2 (last page)**

Patients Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family, Social, and Cultural Characteristics**

1. Are you able to pay for your medications? Yes No
2. Are you able to meet your daily (food, housing, sleep, etc.) needs? Yes No
3. How many people are in your family? 1 2 3 4 5 other: \_\_\_\_\_

**Communication Needs**

1. Do you have any vision impairments? Yes No
2. Do you have any cognitive issues? Yes No
3. Do you have any hearing problems? Yes No

**Health Literacy**

1. Are you aware what medication you take and their side effects? Yes No
2. Are you able to understand the results of your blood tests, imaging, etc.? Yes No

**Social Interaction**

1. Do you interact with other? Yes No
2. Do you enjoy interacting with others? Yes No

**Recreational Drug Use**

1. Do you use recreational drugs? Yes No
2. Have you or any member of your family been hospitalized for any psychiatric reasons? Yes No
3. Have you ever used needles to inject drugs? Yes No

**Alcohol Use**

1. Do you drink? Yes No
2. What do you drink? Wine Beer Hard Liquor
3. How often do you drink? Daily Weekly Monthly Socially
4. How much do you drink? 1-2 drinks 3-4 drinks 5-6 drinks 7-9 drinks 10 or more drinks

**Occupation/Education** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Advanced Care Planning**

1. Do you currently have a living will? Yes No
2. Do you currently have a durable power of attorney for healthcare? Yes No
3. If so, who is your power of attorney for healthcare?

Name: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please provide us with copies of the above)

**Thank you for your time and assisting us in keeping your medical records accurate.**