# Dunkirk Family Practice PA

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Name: ______________________________________________ Date of Birth: ___________

Primary Care Provider's Name: _____________________________________________

If someone at home helps you with your health care:

Caregiver Name: ________________________ Phone number: ____________________

Email Address: _____________________________________________________________

How do you know this person? (For example, is this your sister, your father, or your friend?)
___________________________________________________________________________

If you see any other doctors, case managers or care providers, who else is on your care team?

| Name | They help take care of my: | Contact Number | When to call this Team Member | Next Appointment |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |

We would like to get to know you better.

The language you are most comfortable speaking is: __________________________.

Do you require language assistance for your appointments? ◻ Yes ◻ No

You like to communicate about important things by: (Check all that apply)
◻ talking on the telephone ◻ sending and receiving text messages
◻ using email ◻ receiving regular post office mail

Your cell phone number: ____________________

Name:

Your email address: ______________________

**Your Health History (Medical Conditions, things you are worried about, or barriers or issues that could keep you from reaching your health goals):**

| 1. | 8. |
|---|---|
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

**Health Problems Experienced by your Family Members (Please list):**

| Your Mother: | Your Father: | Your Siblings: | Your Children: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Do you smoke (Check one)? □No, never. □Yes. (How many cigarettes and how often? ______________________) □I used to smoke. (When did you quit? __________________/How much did you used to smoke, and for how long?____________)

When was your last colonoscopy? ________________________________________________

(Women) When was your last mammogram? ____________________________________

(Diabetics) When was your last eye exam? ____________________________________

How healthy do you feel today?

□ I feel well today. □ I feel my health is getting better.

□ I feel my health is getting worse. □ I feel unwell today. I am having these problems:___________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Name:

**Additional Medications:**
If you are taking any new medicines since your primary doctor last saw you, please list them here:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

On a normal day, I need some help with the following things (Check any that apply):

□ Feeding myself □ Showering or bathing

□ Using the toilet □ Getting dressed

□ Brushing my hair □ Walking or moving from one place to another

□ Managing my finances □ Shopping

□ Preparing meals □ Using the telephone

□ Managing my medications □ Doing basic housework

□ Handling transportation (driving or navigating public transit)

Have you fallen in the past 12 months? □ Yes □ No

Are you worried about falling in the next 6 months? □ Yes □ No

Do any of the following Health Risks apply to you? (Check all that apply):

□ Feelings of anxiety or depression □ Increased stress

□ Trouble with my memory □ Social Isolation

□ Second Hand Smoke □ Physical inactivity

□ Poor nutrition, lack of balanced diet □ Illegal drug use

□ Inability to take medications (cannot afford or does not remember)

Name:

Over the past two weeks, have you felt anxious, down or depressed?
□ Yes □ No

Over the past two weeks, have you experienced little interest or pleasure in doing things? □ Yes □ No

Do you have any concerns with your vision? □ Yes □ No

Do you have any concerns with your hearing? □ Yes □ No

Have you made an Advanced Directive, including the following?

1. Living Will? □ Yes □ No

2. Durable Medical Power of Attorney/Healthcare Proxy? □ Yes □ No

**AUDIT-C Questionnaire**

1. How often did you have a drink containing alcohol in the past year?
   □ Never (0 points) *If you answered Never, score questions 2 and 3 below as zero.
   □ Monthly or less (1 point)
   □ 2 to 4 times a month (2 points)
   □ 2 or 3 times per week (3 points)
   □ 4 or more times a week (4 points)

2. How many drinks did you have on a typical day when you were drinking in the past year?
   □ 1 – 2 (0 points) □ 5 – 6 (2 points) □ 10 or more (4 points)
   □ 3 – 4 (1 point) □ 7 – 9 (3 points)

3. How often did you have 6 or more drinks on one occasion in the past year?
   □ Never (0 points) □ Weekly (3 points)
   □ Less than monthly (1 point) □ Daily or almost daily (4 points)
   □Monthly (2 points)

**DAST Questionnaire**

1. In the past 12 months, did you use any illicit drugs or prescription drugs for non-medical reason? □ Yes □ No

Name:

2. If yes to either of the previous questions, what drugs did you use in the last 12 months (check all that apply)

| | | |
|---|---|---|
| □ Amphetamines | □ Heroin | □ Suboxone |
| □ Barbiturates | □ Inhalation/glues/solvents | □ Prescriptions |
| □ Benzodiazepines | □ K2/Synthetic | □ Psychotic meds |
| □ Cocaine | □ Marijuana | □ Sleeping pills |
| □ Ecstasy | □ Methamphetamines | □ Other |
| □ Fentanyl | □ Opiates | □ Methadone |
| □ Hallucinogens/LSD | | |

**Social Needs Screening Tool**

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
   □ Yes □ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)

| | |
|---|---|
| □ Bug infestation | □ Mold |
| □ Lead paint or pipes | □ Inadequate heat |
| □ Oven or stove not working | □ Water leaks |
| □ None of the above | □ No or not working smoke detectors |

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   □ Often true
   □ Sometimes true
   □ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   □ Often true
   □ Sometimes true
   □ Never true

5. Do you put off or neglect going to the doctor because of distance or transportation?
   □ Yes □ No

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? □ Yes □ No □ Already Shut off

Name:

7. Do you have phone access? □ Yes □ No

8. Do you have Internet access? □ Yes □ No

9. Do problems getting child care make it difficult for you to work or study?
   □ Yes □ No

10. Do you have a job? □ Yes □ No

11. Do you have a high school degree? □ Yes □ No

12. How often does this describe you? I don't have enough money to pay my bills.
    □ Never
    □ Rarely
    □ Sometimes
    □ Often
    □ Always

13. How often does anyone, including family, physically hurt you?
    □ Never
    □ Rarely
    □ Sometimes
    □ Often
    □ Always

14. How often does anyone, including family, insult or talk down to you?
    □ Never
    □ Rarely
    □ Sometimes
    □ Fairly Often
    □ Frequently

15. How often does anyone, including family, threaten you with harm?
    □ Never
    □ Rarely
    □ Sometimes
    □ Fairly often
    □ Frequently

Name:

16. How often does anyone, including family, scream or curse at you?
- □ Never
- □ Rarely
- □ Sometimes
- □ Fairly often
- □ Frequently

17. Would you like help with any of these needs? □ Yes □ No

If there is anything else you would like to discuss with your doctor today, please list here:
______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Patient Signature: ________________________________________Date: ______________

Patient Name (Printed): ________________________________________________________