

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

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

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

Have you had any urinary leakage in the last six (6) months? Yes No
If yes, when I cough or sneeze When I sleep I do not know

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

How often do you currently exercise? Never Daily Every other day
 3-4 times a week Weekly Monthly

Name:

In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (i.e., walking fast, jogging, running dancing, swimming, biking, etc.) (1-7) _____

On average, how many minutes did you usually spend exercising at this level on one of those days? 10 20 30 40 50 60 70 80 90 100 110 120

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

- | | |
|---|--|
| <input type="checkbox"/> Feelings of anxiety or depression | <input type="checkbox"/> Increased stress |
| <input type="checkbox"/> Trouble with my memory | <input type="checkbox"/> Social Isolation |
| <input type="checkbox"/> Second Hand Smoke | <input type="checkbox"/> Physical inactivity |
| <input type="checkbox"/> Poor nutrition, lack of balanced diet | <input type="checkbox"/> Illegal drug use |
| <input type="checkbox"/> Inability to take medications (cannot afford or does not remember) | |

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

Name:

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)
 - 3 – 4 (1 point)
 - 5 – 6 (2 points)
 - 7 – 9 (3 points)
 - 10 or more (4 points)
3. How often did you have 6 or more drinks on one occasion in the past year?
 - Never (0 points)
 - Less than monthly (1 point)
 - Monthly (2 points)
 - Weekly (3 points)
 - Daily or almost daily (4 points)

DAST Questionnaire

1. In the past 12 months, did you use any illicit drugs or prescription drugs for non-medical reason? Yes No
2. If yes to either of the previous questions, what drugs did you use in the last 12 months (check all that apply)
 - Amphetamines
 - Barbiturates
 - Benzodiazepines
 - Cocaine
 - Ecstasy
 - Fentanyl
 - Hallucinogens/LSD
 - Heroin
 - Inhalation/glues/solvents
 - K2/Synthetic
 - Marijuana
 - Methamphetamines
 - Opiates
 - Suboxone
 - Prescriptions
 - Psychotic meds
 - Sleeping pills
 - Other
 - Methadone

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

Name:

2. Think about the place you live. Do you have problems with any of the following?
(check all that apply)
- | | |
|--|--|
| <input type="checkbox"/> Bug infestation | <input type="checkbox"/> Mold |
| <input type="checkbox"/> Lead paint or pipes | <input type="checkbox"/> Inadequate heat |
| <input type="checkbox"/> Oven or stove not working | <input type="checkbox"/> Water leaks |
| <input type="checkbox"/> None of the above | <input type="checkbox"/> 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
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

Name:

- 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

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:

Name:

Patient Signature: _____ Date: _____

Patient Name (Printed): _____