

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: _____.

Name: _____

You like to communicate about important things by: (please circle)

- talking on the telephone
- sending and receiving text messages
- using email
- receiving regular post office mail

Your cell phone number: _____

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 (Circle 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? _____)

Name: _____

Health Risk Assessment

When was your last colonoscopy? _____

(Women) When was your last mammogram? _____

(Diabetics) When was your last eye exam? _____

How healthy do you feel today? (Circle all that apply):

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:

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 (circle any that apply):

- Feeding myself

- Showering or bathing

- Using the toilet

- Getting dressed

- Brushing my hair

- Walking or moving from one place to another

Name:

- 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? (Circle one): Yes No

Are you worried about falling in the next 6 months? (Circle one): Yes No

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

- | | |
|--|---|
| Feelings of anxiety or depression | Increased stress |
| Trouble with my memory | Social Isolation |
| Second Hand Smoke | Inability to take medications
(cannot afford or does not remember) |
| Physical inactivity | Poor nutrition, lack of balanced diet |
| Inadequate nutrition or access to food | Illegal drug use |

Over the past two weeks, have you felt anxious, down or depressed? (Circle one): Yes No

Over the past two weeks, have you experienced little interest or pleasure in doing things? (Circle one): Yes No

Do you have any concerns with your vision? (Circle one): Yes No

Do you have any concerns with your hearing? (Circle one): Yes No

Do you have any concerns with your safety at home? (Circle one): Yes No

Have you made an Advanced Directive, including the following? :

Name:

Health Risk Assessment

- **Living Will? (Circle One):** Yes No

- **Durable Medical Power of Attorney/Healthcare Proxy? (Circle One):**
 Yes No

AUDIT-C Questionnaire

1. How often did you have a drink containing alcohol in the past year?
 - a. Never (0 points) *If you answered Never, score questions 2 and 3 below as zero.
 - b. Monthly or less (1 point)
 - c. 2 to 4 times a month (2 points)
 - d. 2 or 3 times per week (3 points)
 - e. 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?
 - a. 1 – 2 (0 points)
 - b. 3 – 4 (1 point)
 - c. 5 – 6 (2 points)
 - d. 7 – 9 (3 points)
 - e. 10 or more (4 points)

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

DAST Questionnaire (Circle One)

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 (circle all that apply)

- | | | |
|----------------------|------------------------------|-------------------|
| a. Amphetamines | h. Heroin | o. Suboxone |
| b. Barbiturates | i. Inhalation/glues/solvents | p. Prescriptions |
| c. Benzodiazepines | j. K2/Synthetic | q. Psychotic meds |
| d. Cocaine | k. Marijuana | r. Sleeping pills |
| e. Ecstasy | l. Methamphetamines | s. Other |
| f. Fentanyl | m. Opiates | |
| g. Hallucinogens/LSD | n. Methadone | |

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

Patient Signature: _____ Date: _____

Patient Name (Printed): _____