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: _____.

You like to communicate about important things by: (Circle all that apply)

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

Your cell phone number: _____

Your email address: _____

Name:

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? _____)

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: _____

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 (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
- 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

Name:

(cannot afford or does not remember)

Physical inactivity

Poor nutrition, lack of balanced diet

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

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

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

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

AUDIT-C Questionnaire

- 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)

- 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)

Name:

- 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 (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	

Social Needs Screening Tool

- 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? (Circle one):
  Yes No

- Think about the place you live. Do you have problems with any of the following?
  - Bug infestation
  - Mold
  - Lead paint or pipes
  - Inadequate heat
  - Oven or stove not working
  - No or not working smoke detectors
  - Water leaks
  - None of the above

Name:

- 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

- 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

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

- 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

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

- Do you have a job? Yes No

- Do you have a high school degree? Yes No

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

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

Name:

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

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

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

- 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): _____