Yearly Adult Comprehensive Questionnaire

Name: ___________________________ **Birthdate:** _______________ **Date:** __________________

Please Complete the questions below:

Employment status: Working Retired Homemaker Student Other: _______________

Current Occupation (or former if retired): ___________________________

Within the past year have you had:

Immunizations and Screenings:

			Name of immunization or study	Provider name/Location
Yes	**No**	Any immunization at another facility (i.e., flu or pneumonia vaccinations)		
Yes	**No**	Colorectal cancer screening through another physician (Colonoscopy, Cologuard, FOBT, Sigmoidoscopy)		
Yes	**No**	Dilated eye exam		
		FEMALES ONLY	**Date**	**Location**
Yes	**No**	Mammogram		
Yes	**No**	PAP (cervical cancer screening)		

Surgery or other procedure: Please list below. Include where the procedure was done and the physician:

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____

Family History: List any changes since your last complete exam. Include relationship and diagnosis

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Allergies: Please list any new allergies or intolerances below. Please include the reaction i.e., rash.

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Specialists or other healthcare providers: Please list below and include the reason for the visit. (Include dental, chiropractic, eye specialists, OB-Gyn, etc.)

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How would you rate your overall health? Excellent Good Average Below average Poor

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Please answer the following questions:

Depression and Anxiety Screening:

Over the past 2 weeks, have you been bothered by any of the following problems?
(Place an X in the box that applies to you)

PHQ-2 (Depression Screening)	**Not at all**	**Several Days**	**More than half the days**	**Nearly everyday**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
GAD-7 (Anxiety Screening)				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

If you noted any concerns above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle your answer)	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult

Alcohol Screening: **Please circle your response to the questions below.**

Over the past two months:

Yes	No	Have you felt the need to cut down on your drinking?
Yes	No	Have you ever felt annoyed by criticism of your drinking?
Yes	No	Have you felt guilty about your drinking?
Yes	No	Have you ever taken a morning "Eye-opener?"

How Active Are You? (Mark the response that most reflects your activity level in the past two months.)

	I exercise regularly (3 or more times a week for 20 or more minutes most weeks)
	I exercise intermittently
	I do not have an exercise routine, but I am on my feet and active most days.
	I do not have an exercise routine and I am not very active most days.
	Other:

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<u>Your environment and other stressors can make it hard for you to maintain good health. Please help us identify issues that can impact your health by completing all sections of this questionnaire.</u>

Please circle your response to the questions below.

Yes	No	Do you have an advance directive (living will) with someone authorized to make healthcare decisions for you if you are unable to speak for yourself? Please make sure we have a copy on file. Please ask for a form if you do not have one.
Yes	No	Do you have trouble seeing even with glasses?
Yes	No	Do you have trouble hearing even with hearing aids?
Yes	No	Do you have trouble expressing yourself clearly (make your needs known)?
Yes	No	Do you worry about being able to afford enough healthy food for you and your family?
Yes	No	Are you exposed to second-hand smoke on a regular basis?
Yes	No	Are you currently using cigarettes, vaping, cigars, chewing tobacco?
Yes	No	Are you currently using marijuana or other illicit drugs?
Yes	No	Are you currently using narcotic pain medications for reasons other than short-term pain management? (Do you feel compelled to take these medications?)
		In the past 12 months:
Yes	No	Have you missed or canceled a medical appointment because you did not have a way to get there? (No transportation)
Yes	No	Have you decided not to come to the doctor's office because of cost?
Yes	No	Did you miss taking medicine because you could not afford to buy it?
Yes	No	Have you worried about your health insurance coverage?
Yes	No	Have you worried about your ability to pay utility bills?
Yes	No	Have you worried about losing your job or other steady source of income?
		Home safety:
Yes	No	Are you worried about your safety in your neighborhood?
Yes	No	Are you concerned that someone in your home might threaten or physically hurt you?
Yes	No	Are you being bullied by anyone at home, in the community or online?
Yes	No	Do you feel alone or isolated from other people?

X	Please check the boxes that apply to you
	I own my home
	I rent my home (apartment or home)
	I am homeless
	I live with my parents or other family members
	I am worried about losing my home
	My home has problems with mold, bug infestation, lead paint/pipes, or inadequate heating

Office use only:

________________________________ __________________

Physician Signature Date