Dignity Health.

Annual Screening Questionnaire

PATIENT NAME: _____

MRN: _____

DOB: _____

PREVENTATIVE CARE			
Date of last Flu Vaccine:		(Ages 65+) Pneumonia Vaccine (yr/type):	
(Ages 50+) colorectal cancer screening (type/yr/result):	Type: Year: Result:	(Ages 65+) Bone Density:	Date:
Do you see an OB/GYN? ☐ Yes ☐ No ☐ N/A		If yes, name:	
Mammogram (Ages 50+):	Results:	Date of last:	Location:
Pap smear: ☐ Yes ☐ No ☐ N/A		Date of last:	Have you had an abnormal pap smear? ☐ Yes ☐ No

SOCIAL HABITS	
Have you ever used tobacco/nicotine products? ☐ Yes ☐ No	If so, what kind?
Current tobacco/nicotine user? ☐ Yes ☐ No	How many years?
Date quit tobacco/nicotine, if applicable:	Current user: interested in quitting? ☐ Yes ☐ No
Have you ever used THC (marijuana or CBD) products? ☐ Yes ☐ No	If so, what kind?
Current THC (marijuana or CBD) user? ☐ Yes ☐ No	How many years?
Date quit THC (marijuana or CBD), if applicable:	Current user: interested in quitting? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No	If so, what kind?
How much/How often?	Current user: interested in quitting? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No	If so, how often?
Do you use caffeine? ☐ Yes ☐ No	If so, how often?
Do you drink soda or other sugar-sweetened beverages? ☐ Yes ☐ No	If so, how often?
Do you use illicit drugs? ☐ Yes ☐ No	If so, what kind?
How much/How often?	Current user: interested in quitting? ☐ Yes ☐ No

FALL RISK ASSESSMENT – AGES 65 AND OLDER	
Have you had a fall in the past year?	☐ Yes ☐ No
If yes, how many falls:	☐ 1 w/o injury ☐ 1 w/ injury ☐ 2+ (w/wo injury)
Are you unsteady walking, or, do you request assistance?	☐ Yes ☐ No
Do you use any assistive device (i.e: cane, walker, wheelchair)?	☐ Yes ☐ No Type:_____

DEPRESSION SCREENING PHQ-9 (PLEASE CIRCLE THE APPROPRIATE NUMBER TO YOUR RESPONSE)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
			Total =	

How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult
Do you currently have problems getting food, transportation, or affordable housing?	☐ Yes ☐ No *Staff: If answer is "Yes" please provide the full 10 SDOH form to patient.
Do you have problems with obtaining your prescriptions?	☐ Yes ☐ No