***PROBLEM FOCUSED VISIT QUESTIONNAIRE- Ages 18-35***

**This is a multiple page questionnaire- please fill out ALL PAGES before your visit!**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Today's Visit**

What three questions would you like answered today?   
1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there anything you would like to do to improve your health (please circle):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Eat Healthy Diet/Lose Weight** | **Limit Alcohol** | **Be Physically Active** | **Monitor My Blood Sugar and Blood Pressure** |
| **Stop Smoking** | **Cope with Stress** | **Take My Medicine as Prescribed** | **Other** |

How should we contact you? (circle one)No Preference Letter Telephone Web Portal

**End of Life Care**:

Do you want to discuss end of life issues? \_\_\_ Yes \_\_\_ No

Do you have an Advanced Directive/Living Will ? \_\_\_ Yes \_\_\_ No

Do we have a copy on file? \_\_\_Yes \_\_\_ No

**Falls:**

|  |  |  |
| --- | --- | --- |
| Have you fallen in the last year? (check **one** box only) |  | NO |
|  | Once, without injury |
|  | Once WITH INJURY |
|  | 2 Falls or more |
| Do you FEEL UNSTEADY when standing or walking | Yes | No |
| Do you WORRY about falling? | Yes | No |

**Between Visits**

Have you had a specialists or therapists visit since we last saw you? (e.g. eye doctor, bone doctor, dentist, physical therapist, etc.). Please tell us who you saw, and for what:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been to the ER, hospital or another doctor since last seen here? \_\_\_ Yes \_\_\_No   
Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Depression Screen:**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | ***Over the last 2 weeks:*** |
|  |  | have you been bothered by little interest or pleasure in doing things? |
|  |  | have you been feeling down, hopeless or depressed? |

**If you answered YES to either question above, please do the PHQ-9 scale (separate page).**

**Update Your Family History:**

Has anything, new come up? (new illness among blood relatives)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any health problems and causes of death if applicable  I am adopted

First &Last Name Age Medical Problems/Still alive?

Mother \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister(s) \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother(s) \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU EXPERIENCING ANY OF THE FOLLOWING (PLEASE CIRCLE):**

**General symptoms:** fever, weight loss, extreme fatigue   
**Eyes:** double vision, sudden loss of vision

**Ears, nose, mouth and throat:** sore throat, runny nose, ear pain

**Cardiovascular:** chest pain, palpitations

**Respiratory:** cough, wheezing, shortness of breath, can’t climb stairs or walk 1 block

**Gastrointestinal**: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools   
**Genitourinary:** frequent or painful urination, urine leakage, bloody urine, problems with sex or interest in sex

**MEN ONLY**: impotence (problems with erections), slow stream, weak stream, urinating more than once per night "

**WOMEN ONLY**: irregular menstrual periods, vaginal bleeding after menopause, past abnormal Pap smear, hot flashes, birth control needs

**Last Menstrual Period was: (approximate date)**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin:** rash, changing mole

**Sleep**: snoring; difficulty sleeping, stop breathing during sleep, worry about sleep apnea

**Neurological:** headache, persistent weakness or numbness on one side of the body, falling   
**Musculoskeletal:** joint pain, muscle weakness

**Psychiatric:** depression, anxiety, suicidal thoughts

**Endocrine:** excessive thirst, cold or heat intolerance, breast mass

**Hematologic:** unusual bruising or bleeding, enlarged lymph nodes

**Allergic:** hayfever

\_\_I am not having any of the above problems.

Please identify any issues above which are **new** or that you specifically want to address.

**Birth control method** (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RISK FACTORS**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| **Tobacco Status:**  *Within a year of quitting your risk of heart attack drops by 50%. Ask us for help to quit using tobacco. In addition some people are able to quit with the help of the Maine Quit Line: 1-800-207-1230* | Do you now use tobacco? |  |  |
| If yes: what type and how much? | | |
| **Alcohol Use:**  *Men who drink 5 or more drinks in a day or 15 or more drinks/week are at risk of a drinking problem. Women who drink 4 or more drinks in a day or 8 or more drinks/week are at risk of a drinking problem.* | Do drink alcohol? |  |  |
| If yes: how much and how often? | | |
| **Marijuana:** | Do you use marijuana for medical purposes? |  |  |
| Do you use marijuana recreationally? |  |  |
| **Drug Use:** | Have you "street" drugs in the last year? (Include taking other people's prescription drugs; or using heroin or opioids) |  |  |
| **Controlled Substances:** | Do you take prescribed controlled medicines such as narcotics, stimulants or tranquilizers? |  |  |
| **Exercise History:**  *30 minutes walking most days can reduce the risk* of a *heart attack by 30%.* | If no, What type of exercise do you do now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many times a week? (days)\_\_\_\_\_\_\_\_\_\_\_\_  How many minutes per day?\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Nutrition**

Are you on a special diet? YES NO

If so, circle all the diets you follow: Diabetic Low-Salt Low-Fat Low-Carb No-Meat No-Eggs No-Fish Vegetarian Vegan Mediterranean Paleo Gluten-Free Dairy-Free Nut-Free Refined Sugar-Free Weight-Watchers

Other/explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last 12 months:

- we worried our food would run out before we got money to buy more? YES NO

- the food we bought just didn't last, and we didn't have the money to buy more? YES NO