

Patient #: . Patient Name:

PATIENT AND FAMILY HEALTH QUESTIONNAIRE I Decline participation

Have you or anyone in your family had a problem or condition in the following areas:

	Self	Family		Self	Family	Comments
Allergies			Abnormal Bleeding			
Drugs or Medication Reaction			Blackouts			
Tics or Tremors			High Blood Pressure			
Seizures			Kidney problems			
Asthma			Cancer			
Thyroid Problems			Substance Use Disorder			
Heart Disease			Bipolar			
Epilepsy			Suicide			
Diabetes			Mental Retardation			
Chronic Pain Syndrome			Schizophrenia			
6 month post-partum			Eating Disorders			
HIV			ADD,ADHD			
Hepatitis			Nervous Breakdown			
TB			Depression			
STD's			Anxiety			
Nervous breakdown						

Are you or anyone in your family affected by handicaps or restriction on physical activity?

Self	Others	Comments

Any past hospitalizations for illness or surgeries?

Self	Others	Comments

Chronic health conditions or health problems by siblings, parents or other household members?

Self	Others	Comments

Patient #: Patient Name

Patient #: _____ Patient Name: _____

PATIENT AND FAMILY HEALTH QUESTIONNAIRE (continued)

Please rate your health during the past 4 weeks in the following areas:	Excellent	Very Good	Good	Fair	Poor	Very Poor
Overall health?						
How would you rate your present fitness level?						
What is your commitment to regular exercise?						
How well can you identify barriers to regular daily exercise?						
Rate your understanding of the effects of exercise on your health and mood?						
How would you rate your present nutrition level?						
How do you rate your knowledge of healthy meal planning?						
What is your understanding of calorie intake and the effects on health?						
Rate your ability to limit binge or overeating activities?						
What is your level of access to health foods vs. low cost high fat foods?						
Your ability to get at least 6-8 hours of sleep at night?						
What is your present level of access to a sleep environment with no TV?						
How would you rate your ability to limit Alcohol intake prior to sleep?						
Your ability to practice relaxation techniques prior to sleep?						
Rate your access to hobbies that help you relax?						
How would you rate your ability to find activities/hobbies that help you manage stress?						
Describe your ability to find time to regularly engage in social interaction?						
Rate your ability to regularly be part of a social or faith based group?						
What is your ability to recognize barriers to your emotional health?						
What is the current level of your support system?						
Rate your ability to seek out help/support for your overall health?						

Please list all medications both prescription and over the counter:

Medication	Strength	Dosage	Who prescribes this medicine?

Do you have an Advance Directive? I.e. living will, do not resuscitate orders? Yes or No (circle one)

PATIENT AND FAMILY HEALTH QUESTIONNAIRE (continued)

The Alcohol Use Disorders Identification Test

Read questions as written.

1. How often do you have a drink containing alcohol?

- 0 points - Never
- 1 point - Monthly or less
- 2 points - 2 to 4 times a MONTH
- 3 points - 2 to 3 times a WEEK
- 4 points - 4 or more times a week

***Questioner may skip remaining questions, if reply to Question 1 is never, or if both answers to 2 and 3 are 0.**

2. How many units of alcohol do you drink on a typical day when you are drinking?

- 0 points - 1 or 2 drinks
- 1 point - 3 or 4 drinks
- 2 points - 5 or 6 drinks
- 3 points - 7 or 8 or 9 drinks
- 4 points - 10 or more drinks

3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?

- 0 points - Never
- 1 point - Less than monthly
- 2 points - Monthly
- 3 points - Weekly
- 4 points - Daily or almost daily

AUDIT-C Score /12 (complete full questionnaire if score is 3 or more)

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- 0 points - Never
- 1 point - Less than monthly
- 2 points - Monthly
- 3 points - Weekly
- 4 points - Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- 0 points - Never
- 1 point - Less than monthly
- 2 points - Monthly
- 3 points - Weekly
- 4 points - Daily or almost daily

6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?

- 0 points - Never
- 1 point - Less than monthly
- 2 points - Monthly
- 3 points - Weekly
- 4 points - Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

- 0 points - Never
- 1 point - Less than monthly
- 2 points - Monthly
- 3 points - Weekly
- 4 points - Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- 0 points - Never
- 1 point - Less than monthly
- 2 points - Monthly
- 3 points - Weekly
- 4 points - Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- 0 points - No, never
- 2 points - Yes, but not in the last year
- 4 points - Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

- 0 points - No, never
- 2 points - Yes, but not in the last year
- 4 points - Yes, during the last year

The Alcohol Use Disorders Identification Test (AUDIT) Score =

/40 Scores of 8 or more are considered an indicator of hazardous and harmful alcohol use

Patient #: Patient Name:

Tobacco Dependence Questionnaire

Please circle one answer on each question. ***Questioner may skip remaining questions, if reply to Question 1 is never**

How many cigarettes [*times*] per day do you usually smoke [*use your electronic cigarette*]?^a (*assume that one "time" consists of around 15 puffs or lasts around 10 minutes*)

(Scoring: 0–4 times/day = 0, 5–9 = 1, 10–14 = 2, 15–19 = 3, 20–29 = 4, 30+ = 5)

2. On days that you can smoke [*use your electronic cigarette*] freely, how soon after you wake up do you smoke your first cigarette of the day [*first use your electronic cigarette*]?^a

(Scoring: 0–5 minutes = 5, 6–15 = 4, 16–30 = 3, 31–60 = 2, 61–120 = 1, 121+ = 0)

3. Do you sometimes awaken at night to have a cigarette [*use your electronic cigarette*]?^b

(Scoring: Yes = 1, No = 0)

4. If yes, how many nights per week do you typically awaken to smoke [*use your electronic cigarette*]?^b

(Scoring: 0–1 nights = 0, 2–3 nights = 1, 4+ nights = 2)

5. Do you smoke [*use an electronic cigarette*] now because it is really hard to quit?

(Scoring: Yes = 1, No = 0)

6. Do you ever have strong cravings to smoke [*use an electronic cigarette*]?^c

(Scoring: Yes = 1, No = 0)

7. Over the past week, how strong have the urges to smoke [*use an electronic cigarette*] been

(Scoring: None/Slight = 0, Moderate/Strong = 1, Very Strong/Extremely Strong = 2)

8. Is it hard to keep from smoking [*using an electronic cigarette*] in places where you are not supposed to?

(Scoring: Yes = 1, No = 0)

When you haven't used tobacco [*an electronic cigarette*] for a while or when you tried to stop smoking [*using*]...

9. Did you feel more irritable because you couldn't smoke [*use an electronic cigarette*]?^c

(Scoring: Yes = 1, No = 0)

10. Did you feel nervous, restless, or anxious because you couldn't smoke [*use an electronic cigarette*]?^c

(Scoring: Yes = 1, No = 0)

Total scoring: 0–3 = not dependent, 4–8 low dependence, 9–12 medium dependence, 13+ = high dependence

Patient #: Patient Name:

Drug Use Screening Questionnaire (DAST-10)

The following questions concern information about your possible involvement with drugs not related to alcoholic beverages during the past **12 months**. Carefully read each statement and decide if your answer is "Yes" or "No". The circle the appropriate response to the question.

***Questioner may skip remaining questions, if reply to Question 1 is no.**

	Circle your response	
	Yes	No
Have you used drugs other than those required for medical reasons?	Yes	No
Do you abuse more than one drug at a time?	Yes	No
Are you always able to stop using drug when you want to?	Yes	No
Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
Do you every feel bad or guilty about your drug use?	Yes	No
Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
Have you neglected your family because of your use of drugs?	Yes	No
Have you engaged in illegal activities in order to obtain drugs	Yes	No
Have you ever experience withdrawal symptoms when you stopped taking drugs?	Yes	No
Have you had medical problems as a result of your drug use?	Yes	No

Credit for use of this instrument to Author, Harvey A. Skinner, PhD Department of Public Health Sciences University of Toronto Canada

Copyright 1982 by Harvey A. Skinner, PhD Department of Public Health Sciences University of Toronto Canada and Center for Addiction and Mental Health Toronto, Canada.

Patient # Patient Name:

**PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)**

Over the last two weeks, how often have you been bothered by any of the following problems?

Use check to indicate your answer:

	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
1. Feeling down, depressed, or hopeless				
2. Trouble falling or staying asleep, or sleeping too much				
3. Feeling tired or having little energy				
4. Poor appetite or overeating				
5. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
6. Trouble concentrating on things, such as reading the newspaper or watching television.				
7. 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.				
8. Thoughts that you would be better off dead or of hurting yourself in some way				

For office coding _____ + _____ + _____ + _____

= Total Score: _____

If you checked off any problems, 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 one)

Not difficult at all somewhat difficult Very difficult Extremely Difficult