COLLINS MEDICAL
ASSOCIATES 2, P.C.

A Saint Francis *Care* Provider

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Dear _____

You have scheduled your annual physical exam with Dr. _____ on _____ @ _____.

Enclosed you will find a Personal Health Questionnaire Depression Scale (PHQ-9) and a Health Questionnaire. Please complete these forms at home and bring them with you at the time of your appointment. Do not mail these forms back to our office. If you have a Living Will or Advance Directive and we do not currently have a copy, please bring a copy for your medical record.

If you have any questions, please do not hesitate to contact our office and our staff will be happy to assist you.

Sincerely,
Collins Medical Associates

Health Questionnaire

Patient's Name _____ Date of Birth _____

Race American Indian Other **Ethnicity** Decline **Language** _____
Black Asian Hispanic
Decline Unknown Non-Hispanic
Hispanic White

1. **What are the names of your specialists?**

Cardiologist_____	Orthopedist_____
Colon/Rectal_____	Other_____
Dentist_____	Other_____
Eye_____	Podiatrist_____
GI_____	Pulmonary_____
Gynecologist_____	Urologist_____

2. What lab do you use for blood work? Quest Collaborative Clinical Lab
3. What pharmacy do you use? (name, address, phone)_____
_____
_____
4. What is your email address?_____
May we contact you by email?.....yes/no

5. **General Health:** In general, would you say your health is:
Excellent Very Good Good Fair Poor

How much bodily pain have you had during the past 4 weeks?
None Very Mild Mild Moderate Severe Very Severe

6. **Review of Systems:**

a. Do you have difficulty driving, watching TV or reading because of poor eyesight?.....yes / no
b. Can you hear normal conversational voice?.....yes / no
Do you use hearing aids?.....yes / no
c. Do you have problems with your memory?…….. yes / no
d. Do you often feel sad or depressed?..... yes / no
e. Have you unintentionally lost weight in the last 6 months?..... yes / no
f. Do you have trouble with control of your bladder? ……..yes / no
Do you have trouble with control of your bowels?..... yes / no
g. How many falls have you had in the past year?.....#____
h. Do you drink alcohol?..... yes / no
If yes, how many drinks per week?.....#____
i. Do you use tobacco products?.....yes / no
If yes, how many years _____ How many per day _____

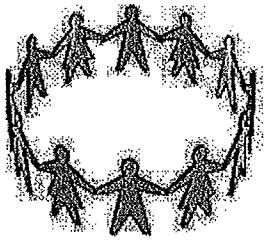
7. Do you live with anyone?…… yes / no
   If yes, who? Spouse Child Other Relative Friend
   Who would help you in an emergency?_____
   Who would help you with heath care decisions if you were not able to communicate your wishes?_____
   Do you have a Living Will for health care?.....yes / no
8. How many medicines do you take, including prescribed, over the counter and vitamins? _____
   What is your system for taking your medications?
   Pill Box Family help List/Chart None
9. Do you use sunscreen?..... yes / no
10. Are you sexually active?..... yes / no
11. Do you drive?.....yes / no
    Do you wear a seat belt?..... yes / no
    Do you wear a helmet?..... yes / no
12. Has anyone intentionally tried to harm you?.....yes / no
13. Are there guns in your household?..... yes / no
14. Have you had an influenza shot (flu shot) this year?..... yes / no
15. Have you had a shot to prevent pneumonia?..... yes / no

16. **Activities of Daily Living:** Are you **(I)** Independent (can do by myself), **(A)** require assistance (need help from another person), or **(D)** Dependent (can not do at all) with the following tasks?

Walking	I	A	D	Using Telephone	I	A	D
Dressing	I	A	D	Shopping	I	A	D
Bathing	I	A	D	Preparing Meals	I	A	D
Eating	I	A	D	Housework	I	A	D
Toileting	I	A	D	Taking Medications	I	A	D
Driving	I	A	D	Managing Finances	I	A	D

Patient Signature:_____ Date:_____
Reviewing Physician:_____ Date:_____

Please bring this completed form and your medications to your appointment. Thank you.



STANFORD PATIENT EDUCATION RESEARCH CENTER

Personal Health Questionnaire Depression Scale (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
*(circle **one** number on each line)*

How often during the past 2 weeks were you bothered by...	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Scoring

If two consecutive numbers are circled, score the higher (more distress) number. If the numbers are not consecutive, do not score the item. Score is the sum of the 9 items. If more than 1 item missing, set the value of the scale to missing. A score of 15 or greater is considered major depression, 20 or more is severe major depression.

Characteristics

Tested on 344 subjects with diabetes.

No. of items	Observed Range	Mean	Standard Deviation	Internal Consistency Reliability	Test-Retest Reliability
9	0-23	6.40	5.73	.88	NA

Source of Psychometric Data

English-language Diabetes Self-Management Study (not yet published).

Comments

This scale available in Spanish.

References

Kroenke K, Spitzer RL, Williams JB, The PHQ-9: Validity of a brief depression severity measure, *Journal of General Internal Medicine*. 2001, 16(9): pp.606-13.

Kroenke K, Spitzer RL, The PHQ-9: A new depression and diagnostic severity measure, *Psychiatric Annals*. 2002, 32: pp. 509-21.

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