PHQ-9

Depression can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient Name: _____

Date of Birth: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please circle 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	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

For office coding: 0 + _____ + _____ + _____

= Total Score: _____

If you circled <u>any</u> 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?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Physician Follow-Up Notes:

DO NOT SCAN

Alcohol Screening Questionnaire (AUDIT)

Patient name: _____

Date of birth: _____

Date: _____

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:


12 oz. beer


5 oz. wine


1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never ○	Monthly or less ○	2-4 times a month ○	2-3 times a week ○	4 or more times a week ○
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2 ○	3 or 4 ○	5 or 6 ○	7-9 ○	10 or more ○
3. How often do you have four or more drinks on one occasion?	Never ○	Less than monthly ○	Monthly ○	Weekly ○	Daily or almost daily ○
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never ○	Less than monthly ○	Monthly ○	Weekly ○	Daily or almost daily ○
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never ○	Less than monthly ○	Monthly ○	Weekly ○	Daily or almost daily ○
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never ○	Less than monthly ○	Monthly ○	Weekly ○	Daily or almost daily ○
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never ○	Less than monthly ○	Monthly ○	Weekly ○	Daily or almost daily ○
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never ○	Less than monthly ○	Monthly ○	Weekly ○	Daily or almost daily ○
9. Have you or someone else been injured because of your drinking?	No ○		Yes, but not in the last year ○		Yes, in the last year ○
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No ○		Yes, but not in the last year ○		Yes, in the last year ○
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
Men:	0-4	5-14	15-19	20+
Women:	0-3	4-12	13-19	20+
ICD-10:	Z13.89	F10.10	F10.10	F10.10

DO NOT SCAN

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Date: _____

Which of the following drugs have you used in the past year?

☐ methamphetamines (speed, crystal)
☐ cannabis (marijuana, pot)
☐ inhalants (paint thinner, aerosol, glue)
☐ tranquilizers (Valium, Xanax)
☐ cocaine
☐ narcotics (heroin, oxycodone, methadone, Vicodin, Norco, etc.)
☐ hallucinogens (LSD, mushrooms)
☐ other _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
Men/Women:	0	1-2	3-5	6+
ICD-10:	Z13.89	F19.10	F19.10	F19.10

DO NOT SCAN

Channel Islands
CALIFORNIA STATE UNIVERSITY

Student Health Services
New Patient Medical History Form

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

(The following information is confidential and will be used only by your medical provider to enhance the level of personal care.)

1. Do you have any allergies to medications? _____
2. Do you have any medical conditions? Ex: Asthma, Allergies, Anemia, Diabetes, High Blood Pressure, ext.
   _____
3. Have you had any procedures/ surgery? _____
4. Do you have any family members with a medical history? If so, who? _____
5. Do you drink alcohol?

   1-2 times a year 1-2 times a month 1-2 times a week 3-5 times per week
6. Do you Smoke? _____
   a. Tobacco use per day: _____ b. Number of years: _____
7. Do you use any drugs? _____
   a. What kind? _____ b. How often? _____

   1-2 times a year 1-2 times a month 1-2 times a week 3-5 times a week
8. Are you taking any medications? _____
   a. Name of meds _____
   b. Dosage for how often_____
9. Do you exercise?

   None Occasional Regular
10. Are you sexually active?

    Yes No
    a. If Yes, how old were you, when you had sex? _____
    b. How many current partners do you have? _____
    c. How many partners have you had during your lifetime? _____
    d. Do you use condoms? _____
    e. What type of contraceptive do you use? Ex: Pills, Nuvaring, IUD, Implant _____
11. Is there any history of sexual abuse? _____
12. Do you have Kaiser Insurance?

    Yes No

Sexual Orientation/Gender Identity (SOGI) Questionnaire

Ventura County Health Care Agency asks the following questions to all of its patients once a year. The intention of this survey is to improve the services provided to you and all of our patients. All of your answers will remain confidential. We appreciate your participation in advance.

Patient name: _____

Date of birth: _____

Date: _____

Do you identify as:

○	Straight or heterosexual
○	Lesbian, gay, or homosexual
○	Bisexual
○	Other
○	Don't know
○	Decline to answer

What is your current gender identity? (Check all that apply)

○	Male
○	Female
○	Transgender male/Trans man/Female-to-male
○	Transgender female/Trans woman/Male-to-female
○	Genderqueer, neither exclusively male nor female
○	Other
○	Decline to answer

Annual Questionnaire

Once a year, all of our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient Name: _____

Date of Birth: _____

Date: _____

Tobacco: Tobacco Products include combustible products (e.g. cigarettes, cigars, little cigars, pipes, hookah), smokeless tobacco products (e.g. chew, spit, Snus) and electronic nicotine delivery systems (e.g. e-cigarettes, e-hookah).

	Yes	No
Do you currently use any tobacco products?	○	○

One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

Alcohol:

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs can include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium, Xanax), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin, Vicodin, Norco).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	○	○

Mood (PHQ-2):

How often have you been bothered by the below symptoms in the last 2 weeks?

	Not at all	Several Days	More than half the days	Nearly Everyday
1. Feeling down, depressed or hopeless	○	○	○	○
2. Little interest or pleasure in doing things	○	○	○	○

DO NOT SCAN