**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.

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle to indicate your answer)</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: 0 + ____ + ____ + ____  
= Total Score: ____

If you circled 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?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

Physician Follow-Up Notes:

**DO NOT SCAN**
Alcohol Screening Questionnaire (AUDIT)

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 (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

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

<table>
<thead>
<tr>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men: 0-4</td>
<td>5-14</td>
<td>15-19</td>
<td>20+</td>
</tr>
<tr>
<td>Women: 0-3</td>
<td>4-12</td>
<td>13-19</td>
<td>20+</td>
</tr>
<tr>
<td>ICD-10: Z13.89</td>
<td>F10.10</td>
<td>F10.10</td>
<td>F10.10</td>
</tr>
</tbody>
</table>
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.

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, Vioodin, Norco, etc.)
- ☐ hallucinogens (LSD, mushrooms)
- ☐ other ____________________________

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

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

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

Men/Women:  

<table>
<thead>
<tr>
<th></th>
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<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1-2</td>
<td>3-5</td>
<td>6+</td>
</tr>
</tbody>
</table>

ICD-10:  

<table>
<thead>
<tr>
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<th>F19.10</th>
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DO NOT SCAN

VENTURA COUNTY HEALTH CARE AGENCY
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?  
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

3/14/2019
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.

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).

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Do you currently use any tobacco products?**

---

**Alcohol:**

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

<table>
<thead>
<tr>
<th>None</th>
<th>1 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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).

<table>
<thead>
<tr>
<th>None</th>
<th>1 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly Everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Feeling down, depressed or hopeless
2. Little interest or pleasure in doing things

**DO NOT SCAN**

---

ADULT ANNUAL QUESTIONNAIRE

VENTURA COUNTY HEALTH CARE AGENCY

VCMC-503-095 (09/2016)