Virginia Mason Franciscan Health

18 to 64-year-old Annual Preventive Visit

Name: ____________________

Date of birth: ____________________

Preferred Name: ____________________ (Optional) Gender pronoun(s): ____________

Concern(s) you wish to discuss today: ____________________

Which medication(s) do you need refilled? ____________________

General Health

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you eat healthy foods most of the time? ☐ Yes ☐ No

Do you always wear your seatbelt when riding in a car? ☐ Yes ☐ No

Have you had dental care within the past 12 months? ☐ Yes ☐ No

In the past 7 days, how many times did you exercise? ____ days. Exercise type: ____________

On days when you exercised, for how long did you exercise? ____ minutes per day

Tobacco Use

☐ No ☐ Yes In the last 30 days, have you used tobacco

If yes, are you interested in quitting in the next month? ☐ Yes ☐ No

______ Number of cigarettes per day ________ Number of years

☐ No ☐ Yes Are you a former smoker?

______ Number of cigarettes per day ________ Number of years ________ Quit Year

Do you think of yourself as ☐ Heterosexual/straight ☐ Homosexual/lesbian/gay ☐ Bisexual

☐ Choose not to disclose ☐ Don't know ☐ Something else ____________

Mood

Do you have a history of depression or are you being treated for depression? ☐ No ☐ Yes

PHQ-9 **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	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 asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite/overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself/family down	0	1	2	3
7. Trouble concentrating, i.e., reading newspaper, watching TV	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 thoughts of hurting yourself in some way	0	1	2	3
PHQ-9 TOTAL				

Patient Name & ID#

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 ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

GAD-7 **Over the last 2 weeks, how often have you been bothered by the following problems?**	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
GAD-7 TOTAL				

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 ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Thank you for completing this form. Please keep it until you are in the exam room. Your provider will review and discuss what is most important to you today.

If you are enrolled in MyVM, this clinic visit note will be available there for review. If not, please let us know so we can provide you with a printed copy.

Patient Name & ID#