Patient Name: _____ DOB: _____ Date Completed: _____

IEHP Annual Patient Questionnaire

IEHP Annual Patient Questionnaire required by government insurance (CIRCLE BEST ANSWER)

Question	Possible Answers
Alcohol Screening: Audit C How often did you have a drink containing alcohol in the past year?	Never Monthly or less 2-4x a month 2-3x per week 4 or more x per week
How many drinks did you have on a typical day when you were drinking in the past year?	None 1 or 2 3 or 4 5 or 6 7-9 10 or more
How often did you have six or more drinks on one occasion in the past year?	Never Less than monthly Monthly Weekly Daily or Almost Daily
Hits Questionnaire Over the last 12 months how often did your partner physically hurt you?	Never Rarely Sometimes Fairly Often Frequently
Over the last 12 months how often did your partner insult you or talk down to you?	Never Rarely Sometimes Fairly Often Frequently
Over the last 12 months how often did your partner threaten you with physical harm?	Never Rarely Sometimes Fairly Often Frequently
Over the last 12 months how often did your partner scream or curse you?	Never Rarely Sometimes Fairly Often Frequently
TB Screening Have you ever had a positive TB skin test?	Yes No
Have you ever had close contact with anyone who was sick with TB?	Yes No
Have you ever been vaccinated with BCG?	Yes No
Other: As a female of childbearing years, are you interested in a prescription of folate to protect the fetus if you get pregnant?	Yes No
IEHP recommends annual screening test for Hepatitis, are you OK with having this lab test?	Yes No

Patient Name: _____ DOB: _____ Date Completed: _____

Are you interested in filling out an Advanced Directive to indicate your end-of-life wishes or preferences of treatment during emergency care?	Yes No

SAMPLE

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

INLAND EMPIRE HEALTH PLAN

Sudden Cardiac Arrest (SCA) & Sudden Cardiac Death (SCD) Screening

- SCA and SCD screening should be performed for all children (athlete or not) at the same time as the Pediatric Physical Examination or at a minimum of every 3 years or on entry into middle or junior high school and into high school.
- AAP recommended 4 questions directed toward SCA and SCD detection for which a positive response suggested an increased risk for SCA and SCD

A positive response from the 4 questions below or an abnormal ECG should prompt further investigation that may include referral to a pediatric cardiologist or pediatric electrophysiologist.		
1. Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, and ringing telephones?	◯ Yes	◯ No
2. Have you ever had exercise-related chest pain or shortness of breath?	◯ Yes	◯ No
3. Has anyone in your immediate family (parents, grandparents, siblings) or other, more distant relatives (aunts, uncles, cousins) died of heart problems or had an unexpected sudden death before age 50? This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or SIDS.	◯ Yes	◯ No
4. Are you related to anyone with HCM or hypertrophic obstructive cardiomyopathy, Marfan syndrome, ACM, LQTS, short QT syndrome, BrS, or CPVT or anyone younger than 50 years with a pacemaker or implantable defibrillator?	◯ Yes	◯ No

◯ **HIGH** Risk needs prompt further investigation	◯ **LOW** Risk

Provider Name: _____ Provider Signature:_____ Assessment Date: _____	Patient Name: _____ Date of Birth: _____

References:
https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-all-children-should-be-screened-for-potential-heart-related-issues/
https://publications.aap.org/pediatrics/article/148/1/e2021052044/179969/Sudden-Death-in-the-Young-Information-for-the
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-017-MRR-Standards.pdf

Created 11/06/2023

Patient Name: _____ DOB: _____ Date Completed: _____

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

8. How often does anyone, including family, insult or talk down to you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

9. How often does anyone, including family, threaten you with harm?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

Patient Name: _____ DOB: _____ Date Completed: _____

10. How often does anyone, including family, scream or curse atyou?1
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

ASSISTANCE

11 Would you like help with any of these needs?
- ☐ Yes
- ☐ No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. https// nam.edu/wp-contenl/ uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Accessed November 14, 2017.

Patient Name: _____ DOB: _____ Date Completed: _____

Hepatitis Risk Assessment Tool

"Hepatitis" means inflammation of the liver and is usually caused by a virus. In the U.S., the most common types are Hepatitis A, Hepatitis B, and Hepatitis C. Millions of Americans are living with viral hepatitis but most do not know they are infected. People can live with chronic hepatitis for decades without having symptoms.

This assessment will help determine if you should be vaccinated and/or tested for viral hepatitis by asking a series of questions. Depending on your answers, you will be given a tailored recommendation that you should discuss with your doctor or your professional healthcare provider. Any information received through the use of this tool is not medical advice and should not be treated as such.

Questions	Recommendations & Explanation
1. Have you ever been diagnosed with a clotting factor disorder?	If yes, talk to your doctor about getting vaccinated for Hepatitis A.
2. Have you ever been diagnosed with a chronic liver disease?	If yes, talk to your doctor about getting vaccinated for Hepatitis A and B.
3. Were you or at least one parent born outside of the United States?	If yes, talk to a doctor about getting a blood test for Hepatitis B. Many parts of the world have high rates of hepatitis B, including the Amazon Basin, parts of Asia, Sub-Saharan Africa and the Pacific Islands.
4. Do you currently live with someone who is diagnosed with Hepatitis B?	If yes, talk to a doctor about getting a blood test for Hepatitis B.
5. Have you previously lived with someone who has been diagnosed with hepatitis B?	If yes, talk to a doctor about getting a blood test for hepatitis B.
6. Have you recently been diagnosed with a sexually transmitted disease (STD)?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
7. Have you been diagnosed with diabetes?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
8. Have you been diagnosed with HIV/AIDS?	If yes, talk to a doctor about getting vaccinated for Hepatitis B and getting a blood test for Hepatitis B and Hepatitis C.
9. If you are a man, do you have sexual encounters with other men?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B.
10. Do you currently inject drugs?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B and C.
11. Were you born from 1945-1965?	If yes, talk to a doctor about getting a blood test for Hepatitis C
12. Have you ever received a blood transfusion or organ transplant before July 1992?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
13. Have you ever received a clotting factor concentrate before 1987?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
14. Have you ever injected drugs, even if just once?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
15. Do you plan on traveling outside of the United States within the next year?	If yes, talk to a doctor about what vaccines may be needed for travel outside the U.S.

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:

NAME: DOB:

The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:
Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 2

Web Version: 2.0; 4.00; 09-19-17

General Instructions:

NAME: DOB:

The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. In the PAST 3 MONTHS, did you have a drink containing alcohol? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you have 4 or more drinks containing alcohol in a day?* (Note: This question should only be answered by females). ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you have 5 or more drinks containing alcohol in a day?* (Note: This question should only be answered by males). ☐ Yes ☐ No

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

c. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking? ☐ Yes ☐ No

d. In the PAST 3 MONTHS, has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. In the PAST 3 MONTHS, did you use heroin? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin? ☐ Yes ☐ No

6. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever? ☐ Yes ☐ No

7. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep? ☐ Yes ☐ No

8. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)? ☐ Yes ☐ No

9. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'), whip-its, etc.)? ☐ Yes ☐ No

If "Yes", answer the following questions:

In the PAST 3 MONTHS, what were the other drug(s) you used?

Comments:

Patient Name_____ Sex: M F Today's Date _____

STD/HIV Risk Screening and Intervention Tool

Questions/Risk Factors	YES	NO
1. Have you had a blood transfusion or received any blood products prior to 1985? ***Blood exposure?***		
2. Have you ever had a job that exposed you to blood or other body fluids? Like a nursing home or a day care or hospital? Doctor's office? Funeral Home? ***Occupational exposure?***		
3. Your medical history tells me that you (do or do not have) the free bleeding disease called Hemophilia. Is that correct? ***Has Hemophilia?***		
4. Has the use of alcohol or any other drug ever caused you to do things sexually that you normally would not do? ***Risky use of alcohol or non-IV drugs?***		
5. Have you **ever** put drugs of any type into your veins? ***Ever an IV drug user?***		
6. Have you ever had any type of infection of the sex organs*?* ***History of STDs?***		
7. Think about the first time you had sex. (Since your last HIV test?) Have you had sex with more than one partner since then? What about your current partner? ***Multiple Sex Partners***?		
8. Some women and some men use sex to get things they need. Have you ever had to do this?		
9. Have you ever been hit, kicked, slapped, pushed or shoved by your partner? ***History of Abuse?***		
10. Some women/men prefer sex with men, some with women and some with both. What type of partner do you prefer? **Circle One: Man Woman Both**		
11. **<u>As far as you know</u>,** have you ever had sex with someone who		
a. was a free bleeder or Hemophiliac?		
b. had HIV or AIDS or an STD?		
c. was a man who had sex with men?		
d. used IV drugs or put drugs into their veins?		
e. was a prostitute - either male or female?		
NOTE: For screening after a previous negative HIV test, ask, "Since your last HIV test ..."		

Documentation instructions and explanations:

1. **Yes or No.** Blood transfusion prior to 1985 places the person at risk for HIV/AIDS.
2. **Yes or No**. Any profession that exposes the patient to body fluids creates a risk for HIV/AIDS.
3. **Yes or No**. Yes, if the patient has Hemophilia; No, if does not have the disease. Hemophilia itself does not create risk for HIV, but the use of blood and blood products by the patient does create risk for HIV/AIDS.
4. **Yes or No.** Use of alcohol or non-IV drugs in a setting/manner that results in sexual risk taking places a person at risk for both STDs and HIV.
5. **Yes or No.** IV drug use is a risk factor for HIV specifically.
6. **Yes or No**. A history of any STD places the patient at risk for another STD including HIV/AIDS.
7. **Yes or No.** Having more than one partner places a patient at risk for both STDs and HIV, unless the partners were prior to 1978.
8. **Yes or No**. Exchanging sex for anything places a person at risk for both HIV and STDs.
9. **Yes or No.** Any type of abuse or coerciveness that the patient has experienced places the patient at risk for both HIV and STDs ,
10. **Circle** the appropriate choice. Male homosexuality and/or male bisexuality are risk factors for HIV/AIDS.
11. **a-e. Yes or No.** Any Yes answer is considered a risk factor for both STDs and HIV/AIDS.

Intervention Documentation: Circle the intervention taken

Level I: - No risk factors identified – No counseling required. Offer "STDs – Don't…" Handout – because "sometimes we change". HIV testing w/counseling is optional – at patient request.

Level II: Risks are related to blood products exposure ONLY – Recommend HIV test. Inform of need for and explain universal precautions. Use "STDs – Don't… " handout.

Level III: Any other risk factor present - significant risk exists. Recommend strongly the HIV test. Test for other STDs as CI. Provide prevention counseling about need for change in (specifically identified) habits and importance of protected sex. Use "STDs – Don't…" handout. Provide skill training in use of condom and in negotiation skills.

Remember: All patients should be given information the handout, "Facts about HIV and HIV testing."

Documentation of HIV testing:

❑ ***HIV Testing Done***

❑ ***<u>NO</u> HIV Test drawn***

IF Patient declined, why? Circle One

- ***** I am not at risk,
- ***** Do not want to know,
- ***** Other

Follow-up Notes:

Signature/title of counselor _____ Date _____

HIV Post Test Counseling

HIV Test Results: Date _____

❑ **HIV positive**

- ○ Test results explained
- ○ Provided emotional assistance related to test result
- ○ Explained need to notify partners/contacts
- ○ Offered options for partner notification
- ○ Stressed need for transmission prevention
- ○ Explained need for early medical evaluation & treatment

❑ **HIV Negative**

- ○ Test results explained
- ○ Counseled re need for safe sex practices
- ○ Scheduled for retest on _____

❑ **Indeterminate**

- ○ Test results explained
- ○ Counseled re need for safe sex practices
- ○ Scheduled for retest on _____

Referrals made:

- ❑ Mental Health_____
- ❑ Partner notification services _____
- ❑ Other Health Care Provider_____
- ❑ Social Services_____
- ❑ Retesting
- ❑ Other_____

Retest Results (Date) _____

Positive Negative Indeterminate

Follow-up Notes:

Additional Post- test counseling

Reason:

Points covered:

Signature/title of counselor _____ Date _____