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

Patient Name: _____ DOB: _____ Date Completed: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ✓ 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 checked off 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?

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

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Patient Name: _____ DOB: _____ Date Completed: _____

Sex: M F

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-JV drugs?*		
5. Have you **ever** put drugs of any type into your veins? *Ever an **JV** drug user?*		
6. Have you ever had any type of infection of the sex organs? *History ofSTDs?*		
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. **As far as you know,** 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 CL 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."

Patient Name: _____ DOB: _____ Date Completed: _____

Documentation of HIV testing:

☐ ***HIV Testing Done***

☐ ***NO 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 positive**

0 Test results explained

0 Provided emotional assistance related to test result

0 Explained need to notify partners/contacts

0 Offered options for partner notification

0 Stressed need for transmission prevention

0 Explained need for early medical evaluation & treatment

■ **HIV Negative**

0 Test results explained

0 Counseled re need for safe sex practices

0 Scheduled for retest on

_____

■ **Indeterminate**

0 Test results explained

0 Counseled re need for safe sex practices

0 Scheduled for retest on

_____

HIV Test Results: Date:

Referrals made:

- ❑ Mental Health _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
- ❑ Partner notification services _ _ _ _ _ _ _ _
- ❑ Provider
- ■ Other Healthcare Services
- ❑ 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** _____

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.

Patient name:_____ **Date:** _____

GPCOG Screening Test

Step 1: Patient Examination

Unless specified, each question should only be asked once

Name and Address for subsequent recall test

1. "*I am going to give you a name and address. After I have said it, I want you to repeat it. Remember this name and address because I am going to ask you to tell it to me again in a few minutes: John Brown, 42 West Street, Kensington.*" (Allow a maximum of 4 attempts).

Time Orientation	**Correct**	**Incorrect**
2. *What is the date?* (exact only)	☐	☐
Clock Drawing – use blank page		
3. *Please mark in all the numbers to indicate the hours of a clock* (correct spacing required)	☐	☐
4. *Please mark in hands to show 10 minutes past eleven o'clock* (11.10)	☐	☐
Information		
5. *Can you tell me something that happened in the news recently?* (Recently = in the last week. If a general answer is given, eg "war", "lot of rain", ask for details. Only specific answer scores).	☐	☐
Recall		
6. *What was the name and address I asked you to remember*		
John	☐	☐
Brown	☐	☐
42	☐	☐
West (St)	☐	☐
Kensington	☐	☐

(*To get a total score, add the number of items answered correctly*
Total correct (score out of 9) **/9**

If patient scores 9, no significant cognitive impairment and further testing not necessary.
If patient scores 5-8, more information required. Proceed with Step 2, informant section.
If patient scores 0-4, cognitive impairment is indicated. Conduct standard investigations.

Informant Interview

Date: _____

Informant's name: _____

Informant's relationship to patient, i.e. informant is the patient's: _____

These six questions ask how the patient is compared to when s/he was well, say 5 – 10 years ago

Compared to a few years ago:

	Yes	No	Don't Know	N/A
▪ Does the patient have more trouble remembering things that have happened recently than s/he used to?	☐	☐	☐	
▪ Does he or she have more trouble recalling conversations a few days later?	☐	☐	☐	
▪ When speaking, does the patient have more difficulty in finding the right word or tend to use the wrong words more often?	☐	☐	☐	
▪ Is the patient less able to manage money and financial affairs (e.g. paying bills, budgeting)?	☐	☐	☐	☐
▪ Is the patient less able to manage his or her medication independently?	☐	☐	☐	☐
▪ Does the patient need more assistance with transport (either private or public)? (If the patient has difficulties due only to physical problems, e.g bad leg, tick 'no')	☐	☐	☐	☐

(***To get a total score, add the number of items answered 'no', 'don't know' or 'N/A')***

Total score (out of 6) ☐

If patient scores 0-3, cognitive impairment is indicated. Conduct standard investigations.

Brodaty et al, *JAGS* 2002; 50:530-534