Pinellas County Primary Care
AND HOSPITALISTS

Name:_____ **Date:**_____ **DOB:** _____

General Information:

Who is completing this form? ☐ Yourself ☐ Spouse ☐ Other:_____

Primary Language: ☐ English ☐ Spanish ☐ Sign language ☐ Other: _____

What is the best way to contact you? ☐ Phone ☐ E-Mail ☐ Other: _____

Are you disabled? ☐ Yes ☐ No **If yes, what is the nature of your disability?**_____

Do you have a living will or advanced directive? ☐ Yes ☐ No **If yes, what type?**_____

If you experienced any of the following issues in the last 10 days, place a check mark next to the symptom.

GENERAL
- ☐ Recent Fever
- ☐ Excessive Fatigue
- ☐ Unexplained Weight Loss
- ☐ Unexplained Weight Gain

SKIN
- ☐ Change in Nails
- ☐ Lumps
- ☐ Recurrent Rashes
- ☐ Sore that will not heal or bleed
- ☐ Moles that are changing

NOSE & SINUSES
- ☐ Bleeding
- ☐ Nasal Congestion
- ☐ Sneezing
- ☐ Loss of Sense of Smell

NECK
- ☐ Lumps
- ☐ Pain

EYES
- ☐ Itching or Watering
- ☐ Discharge
- ☐ Blurred Vision
- ☐ Pain or Burning
- ☐ Loss of Sight

EARS
- ☐ Feeling of Ear Fullness
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing

ENDOCRINE
- ☐ Excessive thirst
- ☐ Unusual intolerance of heat
- ☐ Unusual intolerance of cold
- ☐ Excessive hunger

MENTAL HEALTH
- ☐ Thought of suicide
- ☐ Marital problems
- ☐ Trouble sleeping
- ☐ Panic attacks
- ☐ Anxiety
- ☐ Thoughts of harming others

BREAST
- ☐ Pain
- ☐ Nipple discharge
- ☐ Lumps

CARDIOVASCULAR
- ☐ Swelling of Ankles
- ☐ Abnormal/Irregular heart beat
- ☐ Chest Pain
- ☐ Passing out
- ☐ Leg Pain/Resting
- ☐ Awaken with breathing problems
- ☐ Shortness of Breath
- ☐ Leg Pain/ Walking

MOUTH & THROAT
- ☐ Dry Mouth
- ☐ Mouth Ulcers
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Soreness / bleeding in mouth
- ☐ Dental Issues

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Weakness
- ☐ Shakiness or tremor
- ☐ Fainting spells
- ☐ Seizures/Convulsions
- ☐ Loss of Sensation
- ☐ Numbness
- ☐ Feeling of Tingling in Limbs
- ☐ Speech difficulty

RESPIRATORY
- ☐ Snoring
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing up Blood

UNRINARY
- ☐ Frequent Urination
- ☐ Change in stream
- ☐ Trouble starting to Urinate
- ☐ Waking up to urinate
- ☐ Blood in Urine
- ☐ Pain/burning with Urination

GASTROINTESTINAL
- ☐ Vomiting blood
- ☐ Diarrhea
- ☐ Painful Swallowing
- ☐ Loss of appetite/weight
- ☐ Heartburn
- ☐ Vomiting
- ☐ Nausea
- ☐ Indigestion
- ☐ Food sticks in throat
- ☐ Stomach pain
- ☐ Blood in stool
- ☐ Unable to eat certain foods
- ☐ Constipation
- ☐ Change in bowel habit
- ☐ Black stools

REPRODUCTIVE – WOMEN
- ☐ Pain/trouble during intercourse
- ☐ Leakage of urine
- ☐ Irregular Periods
- ☐ Unusually painful periods
- ☐ Spotting between periods
- ☐ Vaginal discharge/burning/itching

MUSCULOSKELETAL
- ☐ Abdominal Pain
- ☐ Muscle soreness
- ☐Joint pain
- ☐ Joint stiffness

REPRODUCTIVE – MEN
- ☐ Problem with Erection
- ☐ Discharge from penis
- ☐ Pain/trouble during intercourse
- ☐ Pain or swelling of testicles

BLOOD DISORDER
- ☐ Easy Bleeding
- ☐ Easy Bruising

Name: _____ Date: _____

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
☐	☐	☐	☐

Name _____ Date of Birth _____

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Social Needs Screening Tool

Housing

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
    a. Yes
    b. No
2. Think about the place where you live. Do you have a problem with any of the following?
    a. Bug infestation
    b. Mold
    c. Lead paint or pipes
    d. Inadequate heat
    e. Oven/Stove not working
    f. Non-working smoke detectors
    g. Water leaks
    h. 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.
    a. Often
    b. Sometimes
    c. Never
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?
    a. Often
    b. Sometimes
    c. Never

Transportation

5. Do you put off or neglect going to the doctor because of distance or transportation?
    a. Yes
    b. No

Utilities

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
    a. Yes or
    b. No
    c. Already shut off services

Child Care

7. Do problems getting childcare make it difficult for you to work or study?
    a. Yes
    b. No

Employment

8. Do you have a job?
    a. Yes
    b. No

Education

9. Do you have a high school degree?
    a. Yes
    b. No

Finances

10. How often does this describe you? I don't have enough money to pay my bills.
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Always

Personal Safety

11. How often does anyone, including family, physically hurt you?
    a. Never
    b. Rarely
    c. Sometimes
    d. Fairly often
    e. Frequently
12. How often does anyone, including family, insult or talk down to you?
    a. Never
    b. Rarely
    c. Sometimes
    d. Often
    e. Always
13. How often does anyone, including family, threaten you with harm
    a. Never
    b. Rarely
    c. Sometimes
    d. Fairly often
    e. Frequently
14. How often does anyone, including family, scream or curse at you?
    a. Never
    b. Rarely
    c. Sometimes
    d. Fairly often
    e. Frequently

Assistance

15. Would you like assistance with any of these needs?
    a. Yes
    b. No