



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

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

MOUTH & THROAT

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

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

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

BLOOD DISORDER

- ☐ Easy Bleeding
- ☐ Easy Bruising

REPRODUCTIVE – MEN

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

- ☐ Constipation
- ☐ Change in bowel habit
- ☐ Black stools

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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
---	---	---	--



Name: _____

Date:

D.O.B:

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely
2. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely
3. During the past 4 weeks, was someone available to help you if you needed and/or wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself?
☐ Yes ☐ No
4. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
☐ As much as I wanted ☐ Quite a bit ☐ Some ☐ A little ☐ None
5. During the past 4 weeks, how much bodily pain have you generally had?
☐ No pain ☐ Very Mild pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain
6. Can you get places out of walking distance without help? Ex. Can you travel alone on the bus, taxi or drive yourself? ☐ Yes ☐ No
7. Can you shop for groceries or clothes without help? ☐ Yes ☐ No
8. Can you prepare your own meals? ☐ Yes ☐ No
9. Can you do your own housework without help? ☐ Yes ☐ No
10. Can you handle your own finances without help? ☐ Yes ☐ No
11. Do you need help eating, bathing, dressing, or getting around your home?
☐ Yes ☐ No
12. During the past 4 weeks, how would you rate your general health?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
13. How have things been going for you during the past 4 weeks?
☐ Great ☐ Pretty good ☐ Good and bad equally ☐ Pretty bad ☐ Very bad
14. Are you having difficulties driving your car?
☐ Yes, often ☐ Sometimes ☐ No ☐ N/A – I don't have a car
15. Do you always fasten your seatbelt when you are in a car? ☐ Yes ☐ No



Pinellas County Primary Care

AND HOSPITALISTS

Name: _____ Date: _____ D.O.B: _____

16. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up					
Sexual Problems					
Trouble eating well					
Teeth or Dentures					
Problems using the Phone					
Tired or fatigued					

17. Have you fallen 2 or more times in the past year? ☐ Yes ☐ No

18. Are you afraid of falling? ☐ Yes ☐ No

19. Are you a smoker? ☐ Yes ☐ No

20. During the past 4 weeks, how many drinks of wine, beer or any other alcoholic beverages did you have? ☐ 10 – or more per week

☐ 6-9 – per week

☐ 2-5 – per week

☐ 1 – or less per week

☐ 0 – None at all, per week

21. Do you exercise for about 20 minutes 3 or more days per week?

☐ Yes, most of the time

☐ Yes, some of the time

☐ No, I usually do not exercise

22. Have you been given any information to help you with the following

☐ Hazards in your house that might hurt you ☐ Yes ☐ No

☐ Keeping track of your medication? ☐ Yes ☐ No

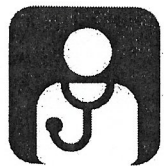
23. How often do you have trouble taking medication the way you have been told to take them?

☐ I do not have to take medication

☐ I always take them as prescribed

☐ Sometimes I take them as prescribed

Name _____ Date of Birth _____



Pinellas County Primary Care

AND HOSPITALISTS

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