Patient ID # _____ Name: _____

Patient Wellness Screen

We are focused on all aspects of your health and wellness. Partnering with our patients is key in providing personalized healthcare. As a part of your annual exam, we are asking you to complete the following questionnaire. Our medical assistants will review the information with you and enter it into your medical record prior to your exam. As always, we encourage you to discuss any concerns you have with your physician or nurse practitioner.

Alcohol Screen

Prescreen:
Do you sometimes drink alcoholic beverages?

- *If the response is **no**, the screening is complete; document **zero** for total*
- *If the response is **yes**, proceed to screening question below*

Screening:
How many times in the past year have you had 4 or more drinks in a day?

- *If the response is **0** times, the screening is complete; document **zero** for total*
- *If the response is **1 or more** times, answer both questions in the table below and document score*

***Questions*:**	**0**	**1**	**2**	**3**	**4**	**Score**
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
How often do you have more than 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

National Institute on Alcohol Abuse & Alcoholism (NIAAA) Screening

Tobacco Screen

Do you currently use tobacco products? ☐ Yes ☐ No If *yes*, please indicate amount: _____

Have you used tobacco products in the past? ☐ Yes ☐ No If *yes*, when did you stop? _____

Are you interested in information on Smoking Cessation? ☐ Yes ☐ No

STD Screen

Are you interested in testing for sexually transmitted diseases (STD)? ☐ Yes ☐ No

Please proceed to reverse side to complete questionnaire

Patient ID # _____ Name: _____

Depression Screen

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
Scoring Value:	**(0)**	**(1)**	**(2)**	**(3)**
Little interest or pleasure in doing things.	□	□	□	□
Feeling down, depressed, or hopeless.	□	□	□	□
Trouble falling asleep, sleeping too much.	□	□	□	□
Feeling tired or having little energy.	□	□	□	□
Poor appetite or overeating.	□	□	□	□
Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	□	□	□	□
Trouble concentrating on things, such as reading the newspaper or watching television.	□	□	□	□
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.	□	□	□	□
Thoughts that you would be better off dead or of hurting yourself in some way.	□	□	□	□

Total Score _____

If you checked off any problem on this questionnaire so far, 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 at all difficult (0)	Somewhat difficult (1)	Very Difficult (2)	Extremely Difficult (3)
□ (0)	□ (1)	□ (2)	□ (3)

Patient Signature: _____ Date: _____ 9/2016