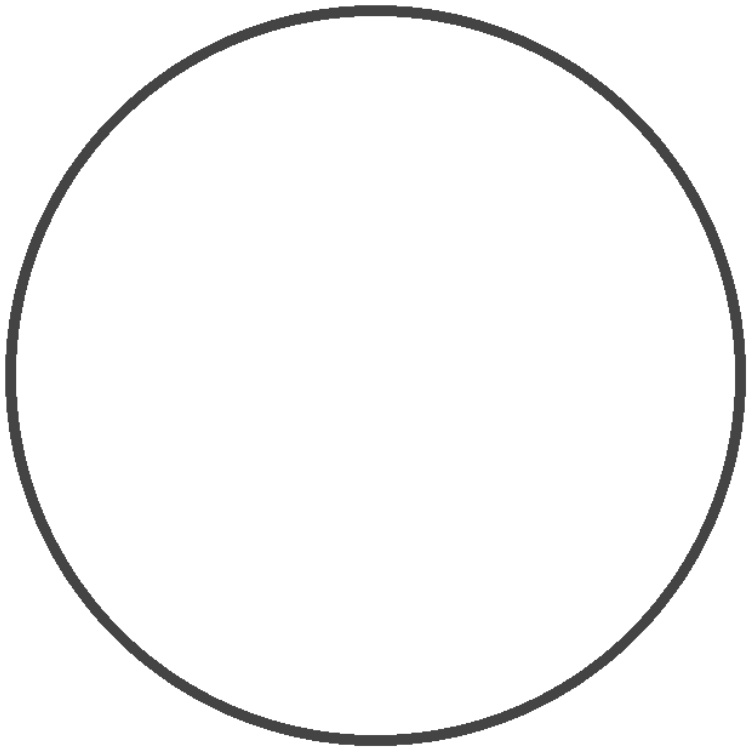
ANNUAL PHYSICAL SCREEN

Patient's Name: _____

Date of Birth: _____ / _____ / _____

COGNITIVE TEST:

Please draw numbers in the circle to make the circle look like the face of a clock. Draw the hands of the clock to read **"10 minutes after 11 o'clock"**



DEPRESSION SCREENING

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.

	Not at all (0)	Several days (1)	More than half the days (2)	Every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

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 ☐ Sometimes difficult ☐ Very difficult ☐ Extremely difficult

ANXIETY SCREENING

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.

	Not at all (0)	Several days (1)	More than half the days (2)	Every day (3)
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid, as if something awful might happen				

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 ☐ Sometimes difficult ☐ Very difficult ☐ Extremely difficult

PREVENTATIVE CARE

HAVE YOU EVER HAD A COLONOSCOPY? ☐ YES ☐ NO

If yes, date of most recent: _____ / _____ / _____

FEMALES ONLY

HAVE YOU EVER HAD A MAMMOGRAM? ☐ YES ☐ NO

If yes, date of most recent: _____ / _____ / _____

Date of last PAP Smear: _____ / _____ / _____

Date of Last Menstrual Period: _____ / _____ / _____

SUBSTANCE USE

DO YOU OR HAVE YOU EVER SMOKED TOBACCO? (SELECT ONE)

☐ Never Smoker

☐ Former Smoker

How many years have you smoked? _____

How much tobacco did you smoke? _____

When did you quit smoking? _____

☐ Current Everyday Smoker

How many years have you smoked? _____

How much tobacco do you smoke? _____

☐ Current Some Days Smoker

How many years have you smoked? _____

How much tobacco do you smoke? _____

Do you or have you used any other forms of tobacco or nicotine? ☐ YES ☐ NO

If yes, please list: _____

WHAT IS YOUR LEVEL OF ALCOHOL CONSUMPTION?

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

WHAT IS YOUR LEVEL OF CAFFEINE CONSUMPTION?

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

DO YOU USE ANY ILLICIT OR RECREATIONAL DRUGS? ☐ YES ☐ NO

If yes, please list: _____

PUBLIC HEALTH AND TRAVEL		
	YES	NO
Have you recently traveled abroad?		
Have you had contact with respiratory secretions from a person with monkeypox?		
Have you been to an area known to be high risk for COVID-19?		

ADVANCED DIRECTIVE		
	YES	NO
Do you have an advanced directive?		
Do you have an out of hospital DNR?		
Do you have a medical power of attorney?		
Do you have a directive to physicians?		
Is blood transfusion acceptable in an emergency?		
Do you have a patient advocate?		

ACTIVITIES OF DAILY LIVING		
	YES	NO
Are you able to care for yourself?		
Do you have difficulty concentrating, remembering or making decisions?		
Do you have difficulty walking or climbing stairs?		
Do you have difficulty dressing or bathing?		
Do you have difficulty doing errands alone?		
Do you have transportation difficulties?		

Which of your hands is dominant? ☐ Right ☐ Left ☐ Bilateral

LIFESTYLE

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?

☐ Not at all ☐ To some extent ☐ Very much
☐ Only a little ☐ Rather much

Do you use your seat belt or car seat routinely?

☐ YES ☐ NO

DIET AND EXERCISE

What type of diet are you following?

☐ Regular ☐ Gluten Free ☐ Cardiac
☐ Vegetarian ☐ Specific ☐ Diabetic
☐ Vegan ☐ Carbohydrate

Do you have any dietary restrictions? ☐ YES ☐ NO

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

What types of sporting activities do you participate in? _____

MARRIAGE AND SEXUALITY

What is your relationship status?

☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Widowed
☐ Other: _____

HOME AND ENVIRONMENT

Where do you live?

☐ Single level house
☐ Multi level house
☐ Apartment
☐ Trailer
☐ Condo
☐ Nursing home
☐ Other: _____

How many children do you have? _____

Do you have any pets? ☐ YES ☐ NO

Do you have smoke and carbon monoxide detectors in your home? ☐ YES ☐ NO

Are there any smokers in your house? ☐ YES ☐ NO

AAFP SOCIAL NEEDS 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?

- ☐ Yes
- ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)

- ☐ 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.

- ☐ 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.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?

- ☐ Yes
- ☐ No

UTILITIES

6. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

- ☐ Yes
- ☐ No
- ☐ Already shut off

CHILDCARE

7. Do problems getting childcare make it difficult for you to work or study?

- ☐ Yes
- ☐ No

EMPLOYMENT

8. Do you have a job?

- ☐ Yes
- ☐ No

EDUCATION

9. Do you have a high school degree?

- ☐ Yes
- ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?

☐ Never (1) ☐ Fairly often (4)

☐ Rarely (2) ☐ Frequently (5)

☐ Sometimes (3)

12. How often does anyone, including family, insult or talk down to you?

☐ Never (1) ☐ Fairly often (4)

☐ Rarely (2) ☐ Frequently (5)

☐ Sometimes (3)

13. How often does anyone, including family, threaten you with harm?

☐ Never (1) ☐ Fairly often (4)

☐ Rarely (2) ☐ Frequently (5)

☐ Sometimes (3)

14. How often does anyone, including family, scream or curse at you?

☐ Never (1) ☐ Fairly often (4)

☐ Rarely (2) ☐ Frequently (5)

☐ Sometimes (3)

ASSISTANCE

15. Would you like help with any of these needs?

☐ Yes

☐ No