BERKELEY FAMILY PRACTICE, LLC

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Returning Patients Visit Form

ANY CHANGES SINCE LAST OFFICE VISIT? ☐ NONE

YES or **NO** *Have you been to the Emergency Room or Hospital since your last visit?* **Date:** _____

YES or **NO** *Have you had any labs, tests, or surgery since your last visit?* **Type:** _____

YES or **NO** *Have you had any medication changes since your last visit?* _____

YES or **NO** *Do you need medication refills?* _____

SOCIAL HISTORY

Do you live alone? **YES** or **NO** (If no, please indicate who lives with you: _____)
Do you feel safe at home? **YES/NO** Do you have access to transportation? **YES/NO** Do you have access to food? **YES/NO**

Over the past two weeks, how often have you been bothered by any of the following problems?

PHQ-9 Depression Questionnaire*	Not at all (0)	Several days (1)	More than half of days (2)	Nearly every day (3)
Little interest or pleasure in doing things?				
Feeling down, depressed or hopeless?				
Trouble falling or staying asleep, or 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 TV?				
Moving or speaking so slowly that other people have noticed, or the opposite – being so fidgety or restless that you have been moving around more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				
Column Score *(Provider Use Only)*				
Total Score *(Provider Use Only)*				

Tobacco Use: Do you smoke cigarettes or use other tobacco products (vaping, chewing tobacco)? **YES** or **NO**

CURRENT SMOKERS:	FORMER SMOKERS:
How many years have you smoked? _____	When did you quit smoking? _____
How many packs per day? _____	How many years did you smoke? _____
	How many packs per day? _____

Drug Use: Any current or previous use of drugs such as marijuana, cocaine, heroin, pills (that do not belong to you), etc.? **YES** or **NO**

- If **YES,** what type of drug(s)? _____ Frequency: _____ How long: _____

Alcohol Use: Please fill out the questionnaire below. (required)

Audit-C Questionnaire*	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times Per month	2-3 times Per week	4+times Per week
How many drinks of alcohol do you have on a normal day?	None, **1-2**	3-4	5-6	7-9	10+
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily (or Almost)
Column Score *(Provider Use Only)*					
Total Score *(Provider Use Only)*					

* REQUIRED BY GOV. QUALITY METRIC SYSTEMS & ADVISED BY MOST INSURANCES

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____