

Patient Information

Name:

Date of Birth:

Please answer the following questions about your health.

Have there been any changes to your medications?

Have there been any changes in your allergies?

**Have you experienced any of the following symptoms in the last 2 weeks?
(Check all that apply)**

- | | |
|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Night | <input type="checkbox"/> Palpitations or Rapid Heart Beat |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Change in Bowels |

PHQ-9 & GAD-7

Patient Name: _____

Over the <u>last 2 weeks</u> , on how many days have you been bothered by any of the following problems?		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 over eating	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

PHQ9 - Total Score

If you checked off any problems, how difficult have these 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

In the past two years have you felt depressed or sad most days, even if you felt okay sometimes?

- Yes No

Over the <u>last 2 weeks</u> , on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

GAD7 - Total Score

If you checked off any problems, how difficult have these 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

If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your doctor, go to the hospital emergency