Patient Name_____ DOB_____

Medical Record Update Questionnaire

A complete and accurate medical record helps assure the best care for you! Please help us keep your chart up to date by answering these questions. Since your answers may change from time to time, we ask these questions often to be sure we have current information to guide your care.

For Everyone (please answer all questions):

1. ***During the last 2 weeks***, have you been bothered by any of the following problems?
   - Little interest or pleasure in doing things (please circle your answer)
     Not at all Several days More than half of the days Nearly every day
   - Feeling down, depressed, or hopeless (please circle your answer)
     Not at all Several days More than half of the days Nearly every day

2. Have you ever used tobacco? **No** **Yes**
   a. If **yes**, did you or do you use it daily? No Yes
   b. What type of tobacco? _____
   c. How much did you or do you smoke? _____ cigarettes/day *or* _____pack(s)/day
   d. What age did you start? _____
   e. If you stopped, what age did you stop? _____

3. Have you ever used e-cigarettes or vaped using Juul or another device*?* **No** **Yes**
   a. If **yes**, did you or do you use it daily? No Yes
   b. At what age did you start? _____
   c. What type of device did/do you use? _____
   d. What nicotine strength did/do you use? _____
   e. If you stopped, what age did you stop? _____

4. How often do you have a drink containing alcohol?
   Never **(skip to question 5)**
   Monthly or less
   2-4 times a month
   2-3 times a week
   4 or more times a week

   How many standard drinks containing alcohol do you have in a typical day when you drink?
   1 or 2
   3 or 4
   5 or 6
   7 to 9
   10 or more

   How often do you have six or more drinks on one occasion?
   Never
   Less than monthly
   Monthly
   Weekly
   Daily or almost daily

(Continued on page 2 – turn over)

5. Within the past 12 months, I/we have worried about whether our food would run out before we had enough money to buy more: **Circle one → Often Sometimes Never**

Within the past 12 months, the food I/we bought just didn't last and we didn't have money to get more: **Circle one → Often Sometimes Never**

6. Exposure to Violence Circle (yes) or (no) for each question, or circle (I decline to specify)

Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? **No Yes N/A**

Within the last year, have you been afraid of your partner or ex-partner? **No Yes N/A**

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? **No Yes N/A**

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? **No Yes N/A**

7. Advance Care Planning

Do you have an advance directive (living will)? **No Yes**

Do you have a healthcare proxy who can make decisions for you if you are unable to do so? **No Yes**

If "yes", please be sure we have the most recent copies!

8. Do you have concerns about your memory? **Yes No**

9. How would you describe your physical activity level?

- **None -** You are not physically active and spend most of your time sitting or resting.
- **Low** - You do light physical activity (able to have a normal conversation while moving).
- **Medium** - You do some moderate physical activity (breathing harder, more difficult to talk while moving) per week.
- **High** - You do 150 or more minutes per week of moderate physical activity, or 75 or more minutes per week of vigorous physical activity (somewhat breathless, very difficult to talk while moving).

If you are age 65 or older:

- Have you fallen in last year? **No Yes**
  - If so, how many times? ____
  - Did the falls result in injury? **No Yes**
- Do you take four or more medicines per day? **No Yes**
- Do you feel unsteady or have problems with balance? **No Yes**
- Do you have a hard time getting up from a chair? **No Yes**