MRN: _____

CPT Code: _____

Physician: _____

Compass Health

Patient Screening Form

Patient Name:_____ Physician Name:_Edward Lee__ Age:____ Gender: M F

DOB:_____ Appt. Date:_____ Diagnosis:_____

Pharmacy: _____ Email address: _____

Have you ever had a Pneumonia vaccine? No ____ Yes ____ Year? ____

Have you had a colonoscopy within the last 9 years? (50-75 years old) No___ Yes___ Year?_____

If yes, which physician ordered the colonoscopy? _____

Do you have a history of colorectal cancer? No____ Yes____

Do you smoke? No____ Yes____

In the past year, how many times have you consumed 5 (for men) or 4 (for women or those 65 + years) or more alcoholic beverages in one day?

None ____ Two or More Times ____

Do you have a history of depression? No____ Yes____ (If yes, please complete questionnaire on the back of this form)

Height _____ Weight _____ (BMI: _____)

Do you have a Power of Attorney? No____ Yes ____

(If *yes*, please provide a copy)

Please provide a current medication list including strength, dosage, and frequency.

WOMEN ONLY:

Have you had a mammogram in the past two years? No____ Yes____

If yes, which physician ordered the mammogram? _____ When? _____

Have you had a mastectomy? No____ Yes____ If yes, was it on both breasts? No____ Yes____

MEN ONLY:

If you have had a diagnosis of prostate cancer, have you had a bone scan? No____ Yes____

If yes, which physician ordered the bone scan? _____ When? _____

Compass Health

Patient Screening Form

MRN: _____

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Over the last two 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
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 overeating	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 hurting yourself	0	1	2	3

*Add Columns

TOTAL:

10. 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 _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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