HME Review of Systems

Exercise: Type	Name:			DOB:	Date:		
Alcohol:drinks/wk				Min:	Per: Day / Week		
Date of last - Tetanus:	Sleep:hrs/night Seat belt: Y/	N	Tobacco/E-cig:/day	When sta	art? When quit?		
Date of last - Tetanus:	Alcohol:drinks/wk Lifetime	non-	medical drug use:				
PLEASE CHECK ALL THAT APPLY (Currently or Recently) weight gain new/changed headache muscle pain weight loss seizure joint pain fatigue dizziness fever passing out gender identity night sweats numbness/tingling sexual orientation tremor/shakiness urinary incontinence hearing difficulties memory loss urinary incontinence hearing difficulties weakness painful urination ear pain urinary urge/frequency seasonal allergies easy bruising/bleeding blood in urine dental problems swollen lymph nodes sexual difficulties/concerns blood clot chest discomfort suicidal thoughts increased stress welling in feet/legs worrisome moles difficulty sleeping MEN: anxiety/nervousness wheezing weakness of urinary stream pushed/shoved/harmed? dishortness of breath nighttime urination domestic violence snoring number of children eating disorder (past or present) sleep apnea WOMEN: nausea number of children living will vomiting number of shortnes nausea num	Date of last - Tetanus:	Pne	eumonia: Shin				
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fever	weight loss		seizure		joint pain		
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visual difficulties	night sweats		numbness/tingling		sexual orientation		
hearing difficulties			tremor/shakiness				
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Name:	DOB

Social Needs Screening Form

		Yes / No
Ŏ	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	YN
	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	YN
	Are you worried that in the next 2 months, you may not have stable housing?	YN
	Do problems getting child care make it difficult for you to work or study? (leave blank if you do not have children at home.)	YN
\$	In the last 12 months, have you needed to see a doctor, but could not because of cost?	Y
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	Y
	Do you ever need help reading hospital materials?	YN
823	Do you often feel that you lack companionship?	YN
!	Are any of your needs urgent? For example: I don't have food for tonight, I don't have a place to sleep tonight.	YN
?	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	YN

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:		DATE:		
Over the last 2 weeks, how often have you been bothered by any of the following problems?				
(use "✓" to indicate your answer)	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 figety 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	0	1	2	3
	add columns	-	+	-
(Healthcare professional: For interpretation of TOT) please refer to accompanying scoring card).	AL, 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?			cult at all nat difficult	
		Extreme	ly difficult	

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