**Name:**
**DOB:**
**Reason for visit:**

**Social History**

- Do you smoke cigarettes? How many per day?________________
- Do you use Smokeless tobacco? _________________
- Do you drink alcohol? If so how often?________________
- Do you use drugs? If so, how often? Which drugs? ________________
- Are you sexually active? _______________
- Are you on birth control or using any contraception? _________________
- Are your sexual partners male or female? _____________________
- Do you have more than one sexual partner at this time? _______________

**Medication history**

- Any Allergies to medications? _______________
- What pharmacy would you like to use? Please include city and street _________________________________
- Which medications are you taking? Include name, dose, and how often you are taking this medication.

**History**

| **Past Medical History** | |
|---|---|
| **Past Surgical History** | |
| **Family History** | |

**Depression screening** *Please answer with a yes or no*

**PHQ2**

| | |
|---|---|
| Little interest or pleasure in doing things | |
| Feeling down, depressed, or hopeless | |

**PHQ-9**

| | |
|---|---|
| Have you had little interest or pleasure in doing things? | |
| Have you been feeling down, depressed or hopeless? | |
| Have you had trouble falling or staying asleep or sleeping too much? | |
| Have you been feeling tired or have little energy? | |
| Have you had a poor appetite or have been overeating? | |
| Have you been feeling bad about yourself, or that you are a failure or have let yourself or family down? | |
| Have you had trouble concentrating on things, such as reading the newspaper or watching TV? | |
| Have you been speaking or moving so slowly that other people could have noticed? Or the opposite – have you been so fidgety or restless that you have been moving around a lot more than usual? | |
| Have you had thoughts that you would be better off dead, or of hurting yourself in some way? | |
| Do any of these cause problems at home, in relationships, or at work? Do they affect your daily life? | |