Pinner Clinic, PA

A Rich History of Medical Tradition Since 1915

Carroll A. Pinner, III, MD Benjamin C. Pinner, MD Edwina Hallman, APRN Catherine Thomas, APRN

Patient Centered Medical Home (PCMH) Questionnaire

Please answer as many questions as you can. Circle your answers and add comments if desired.
Your care team will be able to help answer any questions you may have.

DATE: _____PATIENT NAME: _____DOB: _____

1. Tobacco Smoking Status:	Never / Former / Some Days / Everyday
2. If you smoke, describe how much you smoke:	_____
3. Smokeless tobacco status:	Pipe / Snuff / Cigars / Chewing Tobacco, Dip / Electronic Cigarettes, Vapor
4. Tobacco-years of use:	_____
5. E-cigarette/vape status:	Never/Former/Current
6. Most recent tobacco use screening:	_____
7. Do you have Advanced Directives in place?	Yes / No
8. Do you have a Medical Power of Attorney?	Yes / No
9. What is your current alcohol intake?	None / Occasional / Moderate / Heavy
10. Describe your current caffeine intake:	None / Occasional / Moderate / Heavy
11. Have you had any recent changes in family or social situations?	Yes / No
12. Describe your general stress level:	Low / Medium / High
13. Do you live alone or with others?	Alone / With Others
14. Are you exposed to passive (secondhand) smoke?	Yes / No
15. How would you describe the condition of your mouth and teeth, including false teeth or dentures?	Excellent / Good / Fair / Poor
16. How often do you see or talk to people that you care about and feel close to?	_____days a week
17. In the past year, have been unable to get medicine or medical care when it was really needed?	Yes / No
18. Do you have any family members with known mental health conditions?	Yes / No
19. Do you have any family members with known alcohol abuse?	Yes / No
20. Do you have any family members with known drug abuse? (Prescription/Non-Prescription)	Yes / No
21. Do you have any known mental health conditions?	Yes / No
22. Support systems or programs currently being used?	Yes / No
23. Are you legally blind in one or both eyes?	Yes / No
24. Are you hard of hearing or deaf in one or both ears?	Yes / No
25. Are able to care for yourself?	Yes / No
26. Do you have difficulty concentrating, remembering, or making decisions?	Yes / No
27. Do you have a caregiver?	Yes / No
28. Describe your activity level:	None / Occasional / Moderate / Heavy