**Pinner Clinic, PA**

***A Rich History of Medical Tradition Since 1915***

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