Dear ___________________________,

Welcome to the Menopause Consultation Program.

| Your appointment is on ________________ at ______ am/pm |
| with ____________________________ of the Menopause Consultation Program |
| in Suite 8 on the 1st Floor. |
| Please arrive by _____________ for registration. |

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.

**Please do not mail your packet back to us.**

Please arrive 15 minutes prior to your appointment time to complete registration.

If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance.

**Please Note:** If you arrive later than 15 minutes for your appointment time, you may have to reschedule your appointment.

**Driving directions are enclosed.** Park in the South parking lot. Parking is free.

We look forward to seeing you.

Sincerely,
Menopause Consultation Program Team

01.05.2019
About Your Billing

To our patients:

This letter is to give you notice that the Women’s Medicine Collaborative is an out-patient department of The Miriam Hospital. It is not a private doctor’s office.

Because we are part of the hospital system, you may be responsible for two charges - a facility fee and a fee for physician or other licensed professional services.

You are responsible for all copayment, coinsurance, or deductible payments according to your insurance plan.

We cannot predict the total out-of-pocket expense you will have for your visit. You are strongly encouraged to contact your insurance company prior to your office visit or procedure to understand your responsibility for any copayment, coinsurance, and/or deductible. Your copayment is due at the time of the visit.

Please also ask your insurance company if a referral or prior authorization is necessary.

If you have any questions, please contact our office at (401) 793-5700.

Sincerely,
The Miriam Hospital
doing business as Women’s Medicine Collaborative

Definitions

Facility fee: A facility fee is a legally mandated charge for services given in a hospital-based out-patient department. This is also called "provider-based billing", which is a service charge for the patient's use of the hospital's facility, equipment, and support services.

Copayment (Copay): A fixed amount ($20, for example) you pay for a health care service. Copayments can vary for different services within the same insurance plan, like medications, lab tests, and visits to specialists.

Deductible: The amount you pay for health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of health care services yourself. After you pay your deductible in full, you usually pay only a copay or coinsurance for covered health care services. Your insurance company pays the rest.

Coinsurance: The percentage of the cost of a health care service that you must pay (20%, for example) after you've paid your deductible. For example, if you've paid your deductible in full, and the cost of the service is $100, you must pay 20% of $100, or $20. The insurance company pays the rest.
Women's Medicine Collaborative
Lifespan. Delivering health with care.

DRIVING DIRECTIONS

146/148 West River Street
Providence, RI 02904
(401) 793-5700

From EAST of PROVIDENCE
• From Route 195, merge onto Route 95 North toward Providence
• Follow Route 95 North to Providence
• Take the Branch Avenue exit (Exit 24)
• Turn left onto Branch Avenue
• Follow Branch Avenue to the first traffic light
• At the traffic light, turn left onto West River Street
• Turn right at the stop sign to stay on West River Street
• 146/148 West River Street is on the right (brick mill building)
Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE
• Follow Route 146 South to Providence
• Take the Admiral Street exit
• Turn left onto Admiral Street
• Turn right onto Charles Street/RI-246
• Turn left onto West River Street
• 146/148 West River Street is on the left (brick mill building)
Park in the South parking lot.

From NORTH of PROVIDENCE
• Follow Route 95 South toward Providence (crossing into Rhode Island)
• Take the Branch Avenue exit (Exit 24)
• Turn right onto Branch Avenue
• Follow Branch Avenue to the first traffic light
• At the traffic light, turn left onto West River Street
• Turn right at the stop sign to stay on West River Street
• 146/148 West River Street is on the right (brick mill building)
Park in the South parking lot.

From SOUTH of PROVIDENCE
• Follow Route 95 North to Providence
• Take the Branch Avenue exit (Exit 24)
• Turn left onto Branch Avenue
• Follow Branch Avenue to the first traffic light
• At the traffic light, turn left onto West River Street
• Turn right at the stop sign to stay on West River Street
• 146/148 West River Street is on the right (brick mill building)
Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

GA 02.12.2019
**REGISTRATION FORM**

**PATIENT INFORMATION (PLEASE PRINT)**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date</td>
<td>Social Security #</td>
<td>Email</td>
</tr>
<tr>
<td>Street Address</td>
<td>Home Phone</td>
<td>( )</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Mobile Phone</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

- Single
- Married
- Divorced
- Legally Separated
- Widowed
- Significant Other
- Other: _______________

**Marital Status**

**Preferred Language**

- Spoken: _______________
- Written: _______________

- Interpreter Required? □ YES □ NO

**Sex:**

- Female
- Male

**Religion:** _______________

**Preferred Pharmacy:**

- Name: _______________
- Phone #: _______________

**Are you Employed?**

- □ YES, Full Time
- □ YES, Part Time
- □ YES, Self-Employed
- □ NO, Not Employed
- □ NO, Disabled
- □ NO, Retired
- □ Student, Full Time
- □ Student, Part Time

**Employer**

- Occupation: _______________
- Employer Phone: _______________

**Which provider you are here to see today?**

**How did you hear about us?**

**Primary Care Provider (PCP) / Practice Name**

- PCP Address: _______________
- PCP Phone: _______________

**INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST**

**Person responsible for bill**

- Birth Date: _______________
- Address (if different): _______________
- Home Phone: _______________

**Is this patient covered by insurance?** □ Yes □ No

**Primary Insurance Plan Name**

**Group #**

**Policy #**

**Co-Pay Amount**

**Subscriber’s Name**

**Subscriber’s Birth Date**

**Patient’s relationship to subscriber**

- □ Self
- □ Spouse
- □ Child
- □ Other

**Subscriber’s Employment Status**

- □ Full Time
- □ Part Time
- □ Unemployed

**Subscriber’s Employer**

**Name of secondary insurance (if applicable)**

**Subscriber’s Name**

**Group #**

**Policy #**

**Patient’s relationship to subscriber**

- □ Self
- □ Spouse
- □ Child
- □ Other

**Subscriber’s Employment Status**

- □ Full Time
- □ Part Time
- □ Unemployed

**Subscriber’s Employer**

**IN CASE OF EMERGENCY**

**Name of local friend or relative to contact**

**Relationship to patient**

**Home Phone**

**Mobile Phone**

**The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women’s Medicine Collaborative) or insurance company to release any information required to process my claims.**

**Patient/Guardian signature**

**Date**

**PATIENT PORTAL:** Would you like access to the MyLifespan Patient Portal? □ Yes □ No

**ADVANCED DIRECTIVES:** Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) □ Yes □ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient’s agent) □ Yes □ No I would like the Living Will and Durable Power of Attorney for Healthcare booklet. □ Yes □ No
**ETHNICITY - PLEASE SELECT**

We want to make sure that all our patients get the best care possible. Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.

- [ ] Hispanic or Latino
- [ ] Non-Hispanic/Latino
- [ ] Unknown
- [ ] Prefer not to answer

**RACE - PLEASE SELECT**

- [ ] Unknown
- [ ] Prefer not to answer
- [ ] American Indian or Alaska Native
- [ ] Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian)
- [ ] Black or African American (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African)
- [ ] Native Hawaiian or other Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian)
- [ ] White or Caucasian
- [ ] Other: ____________________________

**PHONE PRIVACY**

In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>HOME</td>
<td>(______)</td>
</tr>
<tr>
<td>MOBILE</td>
<td>(______)</td>
</tr>
<tr>
<td>WORK</td>
<td>(______)</td>
</tr>
</tbody>
</table>

**BEST number to reach you:**
- [ ] Home
- [ ] Mobile
- [ ] Work

**May we leave a general message about appointments?**

<p>| | |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>HOME</td>
<td>Yes</td>
</tr>
<tr>
<td>MOBILE</td>
<td>Yes</td>
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<tr>
<td>WORK</td>
<td>Yes</td>
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</table>

**May we leave a detailed message?**

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<tbody>
<tr>
<td>HOME</td>
<td>Yes</td>
</tr>
<tr>
<td>MOBILE</td>
<td>Yes</td>
</tr>
<tr>
<td>WORK</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Rev. 02/2017
**MEDICAL HISTORY QUESTIONNAIRE**

PLEASE FILL OUT ALL FORMS AND BRING TO YOUR APPOINTMENT

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name: ___________________________ First: ___________________________ DOB: ___________________________

Preferred Language Spoken: ___________________________ Written: ___________________________

Interpreter Required? ☐ YES ☐ NO

Your Physicians

Primary Care Provider: ___________________________ Date last seen: ___________________________

GYN Provider: ___________________________ Date last seen: ___________________________

Other Providers/Specialists:

Name: ___________________________ Specialty: ___________________________ Date last seen: ___________________________

Name: ___________________________ Specialty: ___________________________ Date last seen: ___________________________

Name: ___________________________ Specialty: ___________________________ Date last seen: ___________________________

Which provider referred you to see us?

Briefly describe the reason for your referral and your current symptoms:

---

List all MEDICATIONS (please include non-prescription drugs)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Reason you take this</th>
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</thead>
<tbody>
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</tbody>
</table>

List all ALLERGIES: Medication/Food Reaction

<table>
<thead>
<tr>
<th>Medication/Food</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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Past Medical History (please check all that apply)
- □ Diabetes
- □ High Blood Pressure
- □ Heart Attack
- □ Stroke
- □ Blood Clot
- □ Kidney Disease
- □ Liver Disease
- □ Thyroid Disease
- □ Seizures
- □ Asthma
- □ Anemia
- □ Depression
- □ Anxiety
- □ Bone Fracture
- □ Bleeding tendency (describe): ________________________________
- □ Problems receiving anesthesia (describe): ________________________
- □ Cancer (type) ________________ □ Other ________________________

Screenings
- Colonoscopy: Date: __________ Result: ____________________________
- Last Mammogram: Date: __________ Result: _________________________
- Bone Density: Date: __________ Result: ____________________________

Surgical History (please list procedure and date)
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

Have you ever received a blood transfusion? □ Yes □ No If yes, year ______
Have you had a hysterectomy? □ Yes □ No If yes, reason __________________
Were your ovaries removed? □ No □ Yes (one) □ Yes (both)

OB/GYN HISTORY:
- Number of pregnancies: _______ Number of live births: _______ Miscarriages: _______ Abortions: _______
- Last menstrual period: _______ Age at first period: _______ Occurs every ______ days
- Any abnormal bleeding? □ No □ Yes (describe) ________________________________
- Age at last period: __________ □ N/A
- Birth Control: □ used in the past □ currently use (type) __________________________
- Hormone Replacement Therapy: □ used in the past □ currently use (type) ___________
- Last Pap smear: __________ Result: ________________________________
- Any abnormal PAP smears in the past? □ No □ Yes

Lifestyle and Personal Habits
Who do you live with at home? __________________________ Your occupation __________________________
Do you/have you ever smoked cigarettes? □ Yes □ No If yes, ______ packs/day for ______ years Quit date ______
Do you drink alcohol? □ Yes □ No If yes, ______ number of drinks/week ________________________
Do you use any recreational drugs? □ Yes □ No If yes, what type? ____________________________
Have you ever been treated for problems with alcohol or drugs? □ Yes □ No

Cancer Family History
Thinking about all your BLOOD relatives from your mother and father’s family, please indicate if anyone has/had any of the following. If yes, please write their relationship to you.
For example: mother’s cousin, father’s aunt, etc.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relationship to You</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Uterine cancer</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Endometrial cancer</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Other cancer</td>
<td>□ No □ Yes</td>
</tr>
</tbody>
</table>

Describe: ____________________________
**REVIEW OF SYSTEMS**

<table>
<thead>
<tr>
<th>Constitutional Symptoms</th>
<th>Y</th>
<th>N</th>
<th>Head and Neck</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight gain/loss</td>
<td></td>
<td></td>
<td>Dizziness/Vertigo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fevers</td>
<td></td>
<td></td>
<td>Double vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night sweats</td>
<td></td>
<td></td>
<td>Any vision changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daytime hot flashes</td>
<td></td>
<td></td>
<td>Nose bleeds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td>Sore throat/Pain swallowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of appetite</td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiac</th>
<th>Y</th>
<th>N</th>
<th>Respiratory</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain/heaviness</td>
<td></td>
<td></td>
<td>Cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath with activity</td>
<td></td>
<td></td>
<td>Wheeze</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath at rest</td>
<td></td>
<td></td>
<td>Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular heart beat/Palpitations</td>
<td></td>
<td></td>
<td>Blood in sputum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lightheadedness/Fainting</td>
<td></td>
<td></td>
<td>Early waking/Snoring</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal</th>
<th>Y</th>
<th>N</th>
<th>Genitourinary</th>
<th>Y</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
<td>Frequent voiding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
<td></td>
<td></td>
<td>Pain with voiding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td></td>
<td></td>
<td>Blood in urine</td>
<td></td>
<td></td>
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<tr>
<td>Constipation or Diarrhea</td>
<td></td>
<td></td>
<td>Vaginal dryness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood with stools</td>
<td></td>
<td></td>
<td>Sexual dysfunction</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Pain with sexual activity</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Endocrine</th>
<th>Y</th>
<th>N</th>
<th>Hematologic</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heat/cold intolerance</td>
<td></td>
<td></td>
<td>Abnormal bleeding/bruising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive thirst</td>
<td></td>
<td></td>
<td>Clotting problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive voiding</td>
<td></td>
<td></td>
<td>Transfusion problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive appetite</td>
<td></td>
<td></td>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive hair growth</td>
<td></td>
<td></td>
<td>Blood clots</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th>Y</th>
<th>N</th>
<th>Neuro-Psychiatric</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint pain/swelling</td>
<td></td>
<td></td>
<td>Seizures</td>
<td></td>
<td></td>
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<tr>
<td>Stiffness</td>
<td></td>
<td></td>
<td>Numbness</td>
<td></td>
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<tr>
<td>Weakness of limbs</td>
<td></td>
<td></td>
<td>Weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back pain/Sciatica</td>
<td></td>
<td></td>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gout</td>
<td></td>
<td></td>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ob-Gyn</th>
<th>Y</th>
<th>N</th>
<th>Breast Health</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnanies</td>
<td>If yes, how many?</td>
<td></td>
<td>Breast cysts/lumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live births</td>
<td>If yes, how many?</td>
<td></td>
<td>Breast skin changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-section</td>
<td>If yes, how many?</td>
<td></td>
<td>Nipple discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual period regular</td>
<td></td>
<td></td>
<td>Breast pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postmenopausal Last Period</td>
<td></td>
<td></td>
<td>Recent mammogram</td>
<td></td>
<td></td>
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<tr>
<td>Postmenopausal bleeding</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Recent PAP Smear</td>
<td></td>
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</tbody>
</table>

Thank you for providing us with this important information.

Patient’s Signature: ___________________________ Date: ___________________________

03.05.2019
Women's Health Initiative Insomnia Rating Scale

NAME: ___________________________________________ Date of Birth: ____________________

In the past 4 weeks (Please circle your answer):

Did you take any kind of medication or alcohol at bedtime to help you sleep?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you wake up earlier than you planned to?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you have trouble getting back to sleep after you woke up too early?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you nap during the day?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you have trouble falling asleep?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.

Did you snore?
(0) no, not in past 4 weeks
(1) yes, less than once a week
(2) yes, 1 or 2 times a week
(3) yes, 3 or 4 times a week
(4) yes, 5 or more times a week.
(5) I don’t know

Overall, was your typical night’s sleep during the past 4 weeks:
(0) very sound or restful
(1) sound or restful
(2) average quality
(3) restless
(4) very restless?

About how many hours of sleep did you get on a typical night during the past 4 weeks?
(0) 10 or more hours
(1) 9 hours
(2) 8 hours
(3) 7 hours
(4) 6 hours
(5) 5 or less hours.

# Patient Health Questionnaire-9 (PHQ-9)

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

*(Use "✓" to indicate your answer)*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For office coding**

\[ 0 + \quad + \quad + \quad + \quad = \text{Total Score: } \quad \]

**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?**

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>□</strong></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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