Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**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 fidgety 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 in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Public Health and Travel

Have you been to an area known to be high risk for COVID-19?

Yes / No

In the 14 days before symptom onset, have you had close contact with a laboratory-confirmed COVID-19 while that case was ill?

Yes / No

In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill?

Yes / No

Do you reside in or have you traveled to an area where Ebola virus transmission is active?

Yes / No

Have you processed blood or body fluids from an Ebola virus disease patient without appropriate PPE?

Yes / No

Have you recently or are you planning to travel to an area with Zika virus?

Yes / No

Substance Use

Do you or have you ever smoked tobacco?

Yes / No

Do you or have you ever used any other forms of tobacco or nicotine?

Yes / No

What is your level of alcohol consumption?

None/ Occasional/ Moderate Heavy

Do you use any illicit or recreational drugs?

Yes / No

What is your level of caffeine consumption?

None/ Occasional/ Moderate/ Heavy

Home and Environment

Have there been any changes to your family or social situation?

Yes / No

Do you have any pets?

Yes / No

Do you have smoke and carbon monoxide detectors in your home?

Yes / No

Are you passively exposed to smoke?

Yes / No

Do you use insect repellent routinely?

Yes / No

Do you use sunscreen routinely?

Yes / No

Education and Occupation

What is the highest grade or level of school you have completed or the highest degree you have received?

_____

Are you currently employed?

Yes / No

Marriage and Sexuality

What is your relationship status?

Married/ Single/ Divorced/ Separated/ Widowed/ Domestic partner /Other

Are you sexually active?

Yes / No

How many children do you have?_____

Activities of Daily Living

Are you able to care for yourself?

Yes / No

Are you blind or do you have difficulty seeing?

Yes / No

Are you deaf or do you have serious difficulty hearing?

Yes / No

Do you have difficulty concentrating, remembering or making decisions?

Yes / No

Do you have difficulty walking or climbing stairs?

Yes / No

Do you have difficulty dressing or bathing?

Yes / No

Do you have difficulty doing errands alone?

Yes / No

Are you able to walk?

Yes / No

Do you have transportation difficulties?

Yes / No

Lifestyle

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?

Not at all/ Only a little/ To some extent/ Rather much/ Very much

Do you use your seat belt or car seat routinely?

Yes / No

Diet and Exercise

What type of diet are you following?

Regular/ Vegetarian/ Vegan/ Gluten free/ Specific/ Carbohydrate/ Cardiac/Diabetic

What is your exercise level?

None/Occasional/Moderate/Heavy

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____