COT Annual Visit Questionnaire

Virginia Mason Franciscan Health

INTERVAL HISTORY

Location of pain: _____

Onset (year): _____

New areas of pain since previous visit? ☐ **No** ☐ **Yes: location:** _____

In the last month, have you had any of the following symptoms?

Yes	No	
☐	☐	Shortness of breath
☐	☐	Edema (leg swelling)
☐	☐	Constipation
☐	☐	Mental cloudiness, drowsiness or over-sedation
☐	☐	Unsteady when walking
☐	☐	Poor libido (low sex drive)
☐	☐	Fall
☐	☐	Other accidental injury

Since your last pain management visit have any of the following occurred?

Yes	No	
☐	☐	Accident while operating a motor vehicle
☐	☐	DUI or police arrest
☐	☐	Fainting spell
☐	☐	ED or hospital visit
☐	☐	Other accidental injury

When did you take your last dose of opiate pain medication?_____Hours ago (or) _____Days ago

PEG PAIN SCREENING TOOL

Circle the number that best describes your <u>pain on average</u> in the past week:

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Circle the number that best describes how, during the past week, pain has interfered with your <u>enjoyment of life</u>:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Circle the number that best describes how, during the past week, pain has interfered with your <u>general activity</u>:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?		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 asleep, 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 over eating	0	1	2	3
6	Feeling bad about yourself- or that you are a failure-or have you let yourself or a family member 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 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

If you have 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?	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

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GENERALIZED ANXIETY DISORDER (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Feeling more 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 it's hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritated	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
If you have checked off ***ANY*** problems, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?		**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

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CURRENT OPIOID MISUSE MEASURE (COMM)

Thinking about the last 30 days, please answer the following questions using the following scale:

	Never	Seldom	Sometimes	Often	Very Often
How often have you had trouble with thinking clearly or had memory problems?	0	1	2	3	4
How often do people complain that you are not completing necessary tasks? (i.e. doing things that need to be dome, such as going to class, work, or appointments)?	0	1	2	3	4
How often have you had to go to someone other than your regularly prescribing physician to get sufficient pain relief from medications? (i.e. from friends, another doctor, Emergency Room, other sources)	0	1	2	3	4
How often have you taken your medication differently from the way they are prescribed?	0	1	2	3	4
How often have you seriously thought about hurting yourself?	0	1	2	3	4
How much of your times was spent thinking about your pain medication? (having enough, taking them, dosing schedule, etc.)	0	1	2	3	4
How often have you been in an argument?	0	1	2	3	4
How often have you had trouble controlling your anger? (road rage, screaming, etc.)	0	1	2	3	4
How often have you needed to take medication belonging to someone else?	0	1	2	3	4
How often have you been worried about how you're handling your pain medication?	0	1	2	3	4
How often have others been worried about how you're handling your medication?	0	1	2	3	4
How often have you had to make an emergency phone call or show up at the clinic without an appointment?	0	1	2	3	4
How often have you gotten angry with people?	0	1	2	3	4
How often have you had to take more medication than was prescribed?	0	1	2	3	4
How often have you borrowed medication from someone else?	0	1	2	3	4
How often have you used your pain medicine for symptoms other than pain? (i.e. to help you sleep, improve your mood or relieve stress?)	0	1	2	3	4
How often have you had to visit the Emergency room?	0	1	2	3	4

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COT Annual Visit Questionnaire

Virginia Mason™

ALCOHOL USE QUESTIONNAIRE

Alcohol use can affect your health and interfere with certain medications and treatments. It is important that we ask some questions about your use of alcohol.

Your answers will remain confidential, so please be honest.

Question 1. Place an "X" in the box that best describes your answer.	0-7	8-14	>14
How many servings of alcohol do you drink in one week?			

Question 2. Place an "X" in the box that best describes your answer.	None	≥1
How many times in the past year have you had 4 or more drinks in a day?		

If your answer to Question 2 is ≥1, please turn this page over and complete the questions on the back.

If you answered 0, your form is complete.

12 fl oz of regular beer	=	**8–9 fl oz of malt liquor** (shown in 12 oz glass)	=	**5 fl oz of table wine**	=	**1.5 fl oz shot of 80-proof spirits** ("hard liquor": whiskey, gin, rum, vodka, tequila, etc.)
						
about 5% alcohol		about 7% alcohol		about 12% alcohol		about 40% alcohol

The percent of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage.

Affix patient label if needed

OVER ⇨

ALCOHOL USE QUESTIONNAIRE

Virginia Mason™

For each question in the chart below, place a CIRCLE in one box that best describes your answer.

	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	____
How many drinks containing alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	____
How often have you had 5 or more drinks, on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	____
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	____
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	____
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	____
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	____
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	____
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	____
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	____

Affix patient label if needed