Patient Summary

Patient Name	
Patient DOB	
Phone Number	
e-mail	
Unit	
Unit Phone Number	
Commander Name	
Commander Phone Number	
Emergency Contact Name	
Emergency Phone Number	

Learning Needs Assessment

Preferred Spoken Language: _____

Preferred Written Language: _____

Preferred Mode of Communication: (pick one)

	Verbal
	Sign Language
	Written
	Assistive Technology
	Communication Device

Preferred Method of Learning: (select all that apply)

	Demonstration
	Printed Materials
	Verbal Explanation
	Video/Educational TV
	Internet
	Other:

Preferred Method of Communication: (pick one)

	No Preference
	Printed Letter
	Phone Call
	Patient Portal
	Secure Email

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

	Never
	Rarely
	Sometimes
	Often
	Always

Cultural/Religious Beliefs that May Affect Care: [ ] Yes [ ] No [ ] Decline to answer. If yes, please explain:

_____
_____
_____

Are there any Barriers to Learning: [ ] Yes [ ] No [ ] Decline to answer. If yes, please explain:

_____
_____
_____

Special Duty Status

	Yes	No
Arming Status/Weapons Qualification		
Aviation (Flight)		
Dive		
Ionizing Radiation Worker		
Jump		
Landing Craft Air Cushion		
Nuclear Field Duty		
Personnel Reliability Program		
Presidential Support Duty		
Special Operations/Warfare		
Submarine		

Pain

DVPRS Pain Scale

	0	No pain
	1	Hardly notice pain
	2	Notice pain, does not interfere with activities
	3	Sometimes distracts me
	4	Distracts me, can do usual activities
	5	Interrupts some activities
	6	Hard to ignore, avoid usual activities
	7	Focus of attention, prevents doing daily activities
	8	Awful, hard to do anything
	9	Can’t bear the pain, unable to do anything
	10	As bad as it could be, nothing else matters

Primary pain location: _____

Pain follow-up

	Pain is being addressed
	Patient agrees to seek medical care
	Other:

Safety

	Yes	No
Abuser present		
Patient afraid of their partner		
Patient afraid to go home		
Physical violence increased in severity		
Partner physically abused children		
Children witnessed violence at home		
Threats of suicide		
Threats of homicide		
Firearm present at home		
Alcohol or substance abuse		

If firearm present at home, is it securely stored? [ ] Yes [ ] No

Do you feel safe at home: [ ] Yes [ ] No If no, please explain:

_____
_____
_____
_____

Supplements

Do you take home dietary supplements: [ ] Yes [ ] No If yes, please list:

_____
_____
_____
_____

Tobacco Use

Do you or have you ever used tobacco products?

	Yes – current everyday tobacco user
	Yes – current some day tobacco user
	Former tobacco user
	Never tobacco user

If yes, which type? (check all that apply)

	Cigarettes
	Smokeless
	Cigars/Pipes
	Electronic Nicotine Delivery Systems (ENDS)

If cigarettes, how many cigarettes do you smoke per day?

	Greater than 30 cigarettes (2 packs)/day
	21-30 cigarettes (1 – 2 packs)/day
	11-20 cigarettes (1/2 – 1 pack)/day
	5-10 cigarettes (1/4 – 1/2 pack)/day
	Less than 4 cigarettes (1/4 pack)/day
	Cigars or pipes but not daily

If cigarettes, how soon after waking do you smoke your first cigarette?

	Less than 5 minutes
	5-30 minutes
	31-60 minutes
	Greater than 60 minutes

If smokeless, how many cans/pouches per week do you use?

	More than 3 pouches/cans
	2-3 pouches/cans per week
	1 pouch/can per week

If smokeless, how soon after waking do you place your first dip?

	Less than 5 minutes
	5-30 minutes
	31-60 minutes
	Greater than 60 minutes

Do you want to quit? [ ] Yes [ ] No
Are you interested in cessation medication? [ ] Yes [ ] No

Nutritional Screen

1a. Lost weight recently without trying? [ ] Yes [ ] No [ ] Unsure

1b. Amount of weight lost (Last 6 months):

	1-5 kg (2-13 lbs)
	6-10 kg (14-23 lbs)
	11-15 kg (24-33 lbs)
	Greater than 15 kg (34 lbs or more)
	Unsure

2. Eating poorly due to decreased appetite? [ ] Yes [ ] No

Do you have any concerns with your teeth that make it difficult to eat? [ ] Yes [ ] No

Do you regularly overeat to the point of feeling sick or make yourself vomit from eating too much? [ ] Yes [ ] No

Have you gained or lost 10 pounds in the past 3 months without trying? [ ] Yes [ ] No

Do you have any food allergies, intolerance, special dietary needs, or ethnic, cultural or religious preferences affecting your dietary needs? [ ] Yes [ ] No

Within the past 12 months, you worried whether your food would run out before you got money to buy more. [ ] Often true [ ] Sometimes true [ ] Never true

Within the past 12 months, the food you bought just did not last you and you did not have the money to get more. [ ] Often true [ ] Sometimes true [ ] Never true

Housing Screen

Over the past year, was there a time when you couldn't pay the rent or mortgage on time? [ ] Yes [ ] No

Over the past year, were you homeless or living in a shelter at any time? [ ] Yes [ ] No

Over the past year, how many places have you lived: ____