Rutland Women's Healthcare

A Department of Rutland Regional Medical Center

Insurance
☐ Medicaid
☐ Medicare
☐ Commercial
☐ None

WOMEN'S HEALTH INITIATIVE

Name: _____ DOB: _____ Today's date: _____

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

ONE KEY QUESTION					
Would you like to become pregnant in the next year?	N/A	Yes	OK Either Way	Unsure	No

EMOTIONAL HEALTH				
Over the past 2 weeks, how often have you been bothered by any of the following problems?				
Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several days	More than half the days	Nearly every day
In the past month, have you wished you were dead or wished you could go to sleep and not wake up?			Yes	No
In the past month, have you had any actual thoughts of killing yourself?			Yes	No

SUBSTANCE ABUSE ASSESSMENT							
1. Do you use tobacco products?					Yes	Sometimes	No
Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)							
Think about your drinking in the past year. A drink means one beer (12 oz.), one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.							
How often do you have a drink containing alcohol?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
How many drinks containing alcohol do you have on a typical day you are drinking?	1 drink	2 drinks	3 drinks	4 drinks	5-6 drinks	7-9 drinks	10 or more drinks
How often do you have 4 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	2-3 times a week	4-6 times a week	Daily
How often have you used marijuana in the past year? (including smoking, vaping, dabbing, or edibles)?		Never	Monthly or less	Several days per month	Weekly	Several (2-4) days per week	Daily (5-7) days per week
How often in the past year have you used prescription medications that were not prescribed to you?		Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
How often in the past year have you taken your own prescription medication more than the way it was prescribed or for different reasons than it's intended purpose?		Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	

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How often in the past year have you used other drugs (for example, heroin, cocaine, salvia, inhalants)?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week

VIOLENCE					
How often does anyone, including family, physically hurt you?	Never	Rarely	Sometimes	Fairly often	Frequently
How often does anyone, including family, insult or talk down to you?	Never	Rarely	Sometimes	Fairly often	Frequently
How often does anyone, including family, threaten you with harm?	Never	Rarely	Sometimes	Fairly often	Frequently
How often does anyone, including family, scream or curse at you?	Never	Rarely	Sometimes	Fairly often	Frequently

FOOD SECURITY			
Within the past 12 months, you worried that your food would run out before you got money to buy more.	Often true	Somewhat true	Never true
Within the past 12 months, the food you bought just didn't last and you didn't have money to buy more.	Often true	Somewhat true	Never true

HOUSING STABILITY
What is your housing situation today?
☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside in on the street, on the beach, in a car, abandoned building, bus or train station, or in a park).
☐ I have housing today, but I am worried about losing housing in the future.
☐ I have housing.

OTHER			
Do you have a Primary Care Provider? If *yes, who:*		Yes	No
Do you have any urgent issues you would like to discuss with our Wellness Coach today?	Yes	Unsure	No
If yes, please describe:			

FOR OFFICE STAFF ONLY			
Referral to Wellness Coach offered?	N/A	YES	NO
If yes, circle one:	Patient agreed	Patient refused	
Date referral was sent:			

ASSESSMENT REVIEWED WITH RRMC STAFF	
Date/Time: _____	Signature of RRMC Staff: _____

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