PATIENT SELF-SCREENING
FAMILY PLANNING DEPARTMENT

Name: _____ Visit date: _____

COMMUNICATION:

Do you have difficulty hearing?	___Yes	___No
Do you wear a hearing aid?	___Yes	___No
Do you have difficulty seeing?	___Yes	___No
Do you wear glasses?	___Yes	___No
Do you have difficulty expressing yourself?	___Yes	___No
Do you have difficulty understanding what people say to you:	___Yes	___No

LANGUAGE:

What is your primary spoken language?	_____	
Do you need a translator?	___Yes	___No

PHYSICAL/EMOTIONAL LIMITATIONS:

Do you require any assistance with the following activities:

Bathing	___Yes	___No
Dressing	___Yes	___No
Toileting	___Yes	___No
Walking	___Yes	___No
Feeding yourself	___Yes	___No
Any other daily activities	___Yes	___No
Are you considered handicapped physically or emotionally?	___Yes	___No
Are you considered to be totally or partially disabled?	___Yes	___No
If yes, what is your disability	_____	

ADAPTIVE EQUIPMENT: (Please circle permanent or temporary)

Wheelchair – permanent or temporary	___Yes	___No
Cane – permanent or temporary	___Yes	___No
Crutches – permanent or temporary	___Yes	___No
Walker – permanent or temporary	___Yes	___No
Prosthesis – arm, leg, eye, other _____	___Yes	___No

CULTURAL/RELIGIOUS CONCERNS:

Do you have any religious or ethnic beliefs that may affect how
We deliver your health care? ___Yes ___No
Examples: Blood transfusions/Vaccinations/Kosher, vegetarian, etc.

HAVE YOU SMOKED CIGARETTES IN THE PAST 12 MONTHS? __Yes __No