

Patient Screening Questionnaire (PSQ)

Shade circles like this: ● ○ ○ ○
 Not like this: ⊗ ⊕ ⊖ ⊗
 Print carefully within rectangles like this:
 Example

First Initial

Last Name

Last 4 of SSN

Today's Date

 / /

M M D D Y Y Y Y

This questionnaire helps us understand your past and current health in order to give you the best possible care. The information you provide will only be shared with your health care providers unless you give written permission for others to view it. Please answer every question by filling in the circle next to your response. Fill in only one circle for each question.

	No, never	Yes, but not in the last year	Yes, in the last year
1. a. Has there been a time when for most of the day, every day for at least two weeks, you felt down, depressed, hopeless, or blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Has there been a time when for most of the day, every day for at least two weeks, you felt little interest or pleasure in doing things that you normally enjoy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have you been told by a doctor, nurse, or other health care professional that you had <u>major (or clinical) depression</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Have you been prescribed an <u>anti-depressant medication</u> [such as Prozac (fluoxetine), Celexa (citalopram), Paxil (paroxetine), Zoloft (sertraline), Effexor (venlafaxine), Serzone (nefazodone), Elavil (amitriptyline), Tofranil (imipramine), nortriptyline, desipramine, etc?]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IF YES: Did the medication help?		<input type="radio"/> Yes	<input type="radio"/> No
2. a. Have you been told by a doctor, nurse, or other health care professional that you had <u>manic-depression or bipolar disorder</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you been prescribed a <u>mood-stabilizing medication</u> [such as lithium, Tegretol (carbamazepine), or Depakote (divalproex)?]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IF YES: Did the medication help?		<input type="radio"/> Yes	<input type="radio"/> No
3. a. Has there been a time, lasting at least a month, when you were bothered by memories, dreams, or flashbacks of a traumatic event, or went out of your way to avoid reminders of the event?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you been told by a doctor, nurse, or other health care professional that you have <u>post-traumatic stress disorder (PTSD)</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. a. Have you been told by a doctor, nurse, or other health care professional that you had <u>schizophrenia, schizoaffective disorder, or a psychotic episode</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you been prescribed an <u>anti-psychotic medication</u> [such as Risperdal (risperidone), Zyprexa (olanzapine), Seroquel (quetiapine), Geodon (ziprasidone), Haldol (haloperidol), Thorazine (chlorpromazine), etc?]	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IF YES: Did the medication help?		<input type="radio"/> Yes	<input type="radio"/> No

Please turn the sheet over and continue →

1499



No, never **Yes, but not in the last year** **Yes, in the last year**

5. Have you been hospitalized for treatment of psychiatric or emotional problems?

6. How would you describe your tobacco use (cigarettes, chewing tobacco, etc)?

Current user Quit in past year Quit more than one year ago Never used

7. a. Do you **currently** drink alcohol at all? Yes No

b. Have you felt that you might have an alcohol problem, been diagnosed with an alcohol problem, or been in detox, hospitalized, or otherwise treated for an alcohol problem?

c. In the **past year**, how often did you have a drink containing alcohol?

Never Monthly or less 2 to 4 times a month 2 to 3 times a week 4 or more times a week 6 or more times a week

d. In the past year, how many drinks containing alcohol did you have on a typical day when you were drinking?

0 drinks 1 to 2 3 to 4 5 to 6 7 to 9 10 or more

e. In the past year, how often did you have six or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

f. What was the approximate date of your last alcohol use? /

M M Y Y Y Y

8. a. Do you currently use **recreational, nonprescribed** drugs at all? Yes No

b. Have you felt that you might have a drug problem, been diagnosed with a drug problem, or been in detox, hospitalized or otherwise treated for a drug problem?

c. Please list below the drug or drugs that you have used most:

9. Are you interested in hearing about monthly support groups and education groups for people with hepatitis C and their loved ones? Yes No

10. Are you interested in hearing about opportunities to participate in research about hepatitis C? Yes No

