VACS PROVIDER QUESTIONNAIRE

General Medicine Clinic

Year One Follow Up Survey

All of the following questions refer to the patient listed below. Please answer the questions to the best of your ability based on what you know about the patient. Please make your best guess. Please do not ask the patient or consult their medical records. (We are asking the patient some of these questions as well.)

When finished, please return this form to the Research Coordinator who gave it to you. This cover page and the patient identifiers will be destroyed.

Thank you for participating.

Study ID: | | | | | | |

Last Name: | | | | | | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | | | | | | |

SSN: | | | | | | | | | |

DOB: | | | / | | | / | | | | |

Month: Day: Year:

5073636325

PROVIDER QUESTIONNAIRE: GEN MED
Year One Follow Up

Date Form Completed: ☐☐ / ☐☐ / ☐☐☐☐ **Provider ID:** ☐☐☐☐ **Study ID:** ☐☐☐☐☐☐

1. Are you designated as the primary care provider for this patient? ○ YES ○ NO

2. Do you consider yourself primarily responsible for this patient? ○ YES ○ NO

3. How long have you been this patient's provider?

○ < 3 MOS. ○ 3 - 6 MOS. ○ 6 - 12 MOS. ○ 1 - 2 YRS. ○ 2 - 3 YRS. ○ > 3 YRS.

4. Do you like working with this patient? NOT AT ALL ○ ○ ○ ○ ○ VERY MUCH

5. How close is your relationship with this patient?

○ VERY CLOSE ○ SOMEWHAT CLOSE ○ NOT CLOSE AT ALL

6. How sick is this patient?

○ NEAR DEATH ○ VERY SICK ○ MODERATELY SICK ○ SOMEWHAT SICK ○ NOT SICK AT ALL

7. In your best judgement, please estimate the percentage probability that this patient will be alive in 10 years. ☐☐☐ %

8a. Does this patient take any prescription medications? ○ YES ○ NO If no, skip to question 9.

8b. In your best judgement, please estimate the percentage probability that this patient is currently taking > 90% of their prescription medications? ☐☐☐ %

8c. Over the past 3 months, how often has this patient failed to take their prescription medications?

○ NEVER ○ SOME OF THE TIME ○ HALF OF THE TIME ○ MOST OF THE TIME ○ ALL THE TIME

9. Please mark the following behaviors this patient practices:

	Past	Present	Never	Don't Know
Smokes cigarettes	○	○	○	○
Uses illegal drugs	○	○	○	○
Drinks alcohol	○	○	○	○
Drinks alcohol despite harm	○	○	○	○

10. Does this patient have cognitive impairments or dementia?

○ A GREAT DEAL ○ SOME ○ SLIGHT ○ NONE

11. Please mark all of the following comorbid conditions that this patient has ever had.

Psychiatric Comorbid Conditions

	Yes	No	Don't Know
a. Anxiety	○	○	○
b. Depression	○	○	○
c. Post Traumatic Stress Disorder (PTSD)	○	○	○
d. Schizophrenia	○	○	○

General Comorbid Conditions

	Yes	No	Don't Know
e. Alzheimer's Disease or other Dementia	○	○	○
f. Angina or CAD	○	○	○
g. Chronic Pulmonary Disease (COPD/Asthma)	○	○	○
h. Congestive Heart Failure	○	○	○
i. Myocardial Infarction	○	○	○
j. Peripheral Vascular Disease	○	○	○
k. Stroke/TIA	○	○	○