

**VACS PROVIDER QUESTIONNAIRE  
General Medicine Clinic**



**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:



# PROVIDER QUESTIONNAIRE: GEN MED

4714

Date Form Completed:

□□ / □□ / □□□□

Provider ID:

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Study ID:

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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            |                             | Past                  | Present               | Never                 | Don't Know            |
|--------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Smokes cigarettes  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Drinks alcohol              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Uses illegal drugs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Drinks alcohol despite harm | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

11. Does this patient have cognitive impairments or dementia?

A GREAT DEAL  SOME  SLIGHT  NONE

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

### Psychiatric Comorbid Conditions

|  | Yes                   | No                    | Don't Know            |
|--|-----------------------|-----------------------|-----------------------|
| a. Anxiety                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Depression                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Post Traumatic Stress Disorder (PTSD) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Schizophrenia                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

### General Comorbid Conditions

|  | Yes                   | No                    | Don't Know            |
|--|-----------------------|-----------------------|-----------------------|
| e. Alzheimer's Disease or other Dementia   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Angina or CAD                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Chronic Pulmonary Disease (COPD/Asthma) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Congestive Heart Failure                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. Myocardial Infarction                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j. Peripheral Vascular Disease             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| k. Stroke/TIA                              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |