uchealth

AF Williams Family Medicine Center

Patient Identification Label
Name: _____
MRN: _____
DOB: _____
Date of Service: _____

Health starts where we work, play, learn, eat, and sleep. Problems in any of these areas can affect your health. We may be able to provide assistance, so we hope you will answer these questions. You do not have to answer any questions you do not want to. Anything you write will be kept private in your medical record. PLEASE CIRCLE YOUR ANSWERS

1. Is it difficult to get transportation to or from your medical appointments?	No	Yes
2. Is there someone you can rely on when you have problems?	Yes	No
3. Are there enough people you feel close to?	Yes	No
4. In the last 12 months, did you ever worry that your food would run out before you had money to buy more?	No	Yes
5. In the last 12 months, did your food ever not last and you didn't have money to get more?	No	Yes
6. In the last 12 months, did you ever feel stressed about making ends meet? <u>Check the box for anything you have trouble paying for:</u> ☐ Food ☐ Rent/mortgage ☐ Medical care ☐ Prescriptions ☐ Insurance ☐ Gas/Electricity ☐ Childcare ☐ Other: _____	No	Yes
7. Do you have any problems with your housing, such as unsafe/unclean conditions, temporary living or no place to live? <u>Check the box for any housing problems that you are having:</u> ☐ Unsafe conditions ☐ Unclean conditions ☐ Temporary housing ☐ Staying in shelter ☐ No place to live or living on street ☐ Other: _____	No	Yes
8. Does a partner, or anyone at home, hurt, hit or threaten you?	No	Yes
9. How confident are you filling out forms by yourself?	Not at all Somewhat Extremely	
10. How confident are you that you can control and manage most of your health problems? (Select a number from 1 to 10. 1 = not at all confident. 10 = very confident)	1 2 3 4 5 6 7 8 9 10 Not at all	Very confident
11. **Would you like a member of your care team to contact you to provide any additional support or resources?**	No	Yes

Thank you for sharing this information with us.