



THE PATIENT HEALTH QUESTIONNAIRE 2 (PHQ-2)

Patient Name: _____ Date of visit: _____

Have you received a flu vaccine in the past year? Y / N If yes where? _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

- 0 Not at all
- 0 Several days
- 0 More than half the days
- 0 Nearly every day

2. Feeling down, depressed or hopeless

- 0 Not at all
 - 0 Several days
 - 0 More than half the days
 - 0 Nearly every day
-

*CAGE Questions:

1. Have you ever felt you should cut down on your drinking?

Yes No

2. Have people annoyed you by criticizing your drinking?

Yes No

3. Have you ever felt bad or guilty about your drinking?

Yes No

4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Yes No

Signed Name: _____ Printed Name: _____

Witness: _____