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Data Dictionary

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The content outlined herein represents the full range of *patient-reported* data collected by Docket™. Docket™ currently aggregates four types of data: patient-reported data, adherence data, data from Bluetooth-enabled devices, and metadata. Future releases will enable data collection from third-party Electronic Medical Record ("EMR") systems. Our software includes a dynamic health risk assessment that captures a holistic representation of patients' medical histories and other clinical information. **Your patients will *only* answer relevant questions.** Users are prompted to answer different questions based on previous inputs as they navigate the risk assessment questionnaire. Many questions are optional. **These design considerations enable Docket™ to identify underlying health-related concerns and prevent unnecessary data entry.**

As a care provider, you may restrict certain questions based on regulations and/or clinical relevance. Your patients will be alerted if any portion of their health information is prevented from being transmitted to your account [and ultimately, to your EMR system] according to your settings.

Docket™ is a highly economical and sophisticated patient intake solution. Please contact us at info@hellodocket.com if you have any questions and/or feedback.

Glossary

- Actionable – This field allows users to add additional line items such as new insurance coverages, medical conditions, and phone numbers.
- Conditional – Certain answers to this question will hide or unhide additional fields.
- Formatted – The app automatically formats these inputs (e.g. phone numbers or social security numbers).
- Multiple Selection – The user may choose many responses from a pre-determined category list in a "check all that apply" format.
- Single Selection – The user may only choose one response from a pre-determined category list.

Current Visit

This section pertains to current medical issues (e.g. reason for visit, referrals, etc.).

Question	Answer Type	Notes
What brings you in today?	Free Text	
What other concerns do you have today?	Free Text	

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Did you get a flu shot this season?	Binary	
Did anybody refer you?	Binary	Conditional
Referral source:	Single Selection	Conditional
Referring physician:	Free Text	
Cardiac [issues]	Multiple Selection	
Ear, nose, and throat [issues]	Multiple Selection	
Endocrine [issues]	Multiple Selection	
Eyes [issues]	Multiple Selection	
Gastroenterology [issues]	Multiple Selection	
Hematologic [issues]	Multiple Selection	
Mental Health [issues]	Multiple Selection	
Musculoskeletal [issues]	Multiple Selection	
Neurology [issues]	Multiple Selection	
Respiratory [issues]	Multiple Selection	
Skin [issues]	Multiple Selection	

About Me

This section houses demographics, insurance coverages, and other patient identifiers.

Question	Answer Type	Notes
Nickname	Free Text	
Relationship Status	Single Selection	
Sex	Single Selection	Conditional
I identify as:	Single Selection	
Date of Birth	Date Picker	
Social Security Number	Free Text	Formatted
Home Address	Free Text	
Address Line 2	Free Text	
City	Free Text	
State	Single Selection	Abbreviated
Zip	Free Text	Formatted
Add Phone Number	Actionable	
Your Phone Number	Number Pad	Formatted
What kind of phone is this?	Single Selection	
Preferred Method of Contact	Single Selection	
Add Emergency Contact	Actionable	
First Name	Free Text	
Middle Name	Free Text	
Last Name	Free Text	
Your Relationship	Single Selection	
Phone Number	Number Pad	Formatted

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What Kind of phone is this?	Single Selection	
Add Insurance Coverage	Actionable	
Insurance Provider	Free Text	
Street Address	Free Text	
Street Address Line 2	Free Text	
City	Free Text	
State	Single Selection	Abbreviated
Zip	Free Text	Formatted
Are you the subscriber?	Binary	Conditional
Who is the subscriber	Free Text	
First Name	Free Text	
Middle Name	Free Text	
Last Name	Free Text	
Street Address	Free Text	
Street Address Line 2	Free Text	
City	Free Text	
State	Single Selection	Abbreviated
Zip	Free Text	Formatted
Social Security Number	Free Text	Formatted
Phone Number	Number Pad	Formatted
ID or Policy Number	Free Text	
Group or Code Number	Free Text	
Payer ID	Free Text	
Effective Date	Date Picker	
Plan Type	Single Selection	
Rx BIN	Free Text	
Rx PCN	Free Text	
Rx GRP	Free Text	
Is this your primary insurance coverage?	Binary	
Include a photo of your insurance card? (front side)	Photo	
Include a photo of your insurance card? (back side)	Photo	
First Name [of PCP]	Free Text	Formatted (“Dr.”)
Last Name [of PCP]	Free Text	
Email Address [of PCP]	Free Text	
Phone Number [of PCP]	Number Pad	Formatted
Health System Affiliation [of PCP]	Free Text	
Race (select one or more)	Multiple Selection	Optional
Ethnicity	Single Selection	Optional
Religion	Single Selection	Optional

Do needles bother you?	Binary	
Would you prefer to be seen by a male or female physician?	Ternary	
What interests do you have?	Free Text	
What is your favorite activity/sport?	Single Selection	
Favorite pro football team?	Single Selection	
Favorite pro baseball team?	Single Selection	
Favorite pro basketball team?	Single Selection	
Favorite pro hockey team?	Single Selection	

My Medications

Here is a patient-reported inventory of current medications. Adherence data is generated via medication reminders.

Question	Answer Type	Notes
Preferred Pharmacy:	Free Text	
Pharmacy phone number:	Number Pad	Formatted
ADD MEDICATION	Actionable	
Name of Medication	Free Text	Completion Matching
Dosage	Number Pad	
Units	Single Selection	
Do you take this every day?	Binary	Conditional
How often	Multiple Selection	
Frequency	Single Selection	
Was this medication prescribed by a healthcare professional?	Binary	Conditional
Prescribed on	Date Picker	
Prescribed by	Free Text	Formatted (“Dr.”)
Used to treat (e.g. ‘cough’)	Free Text	
Side effects	Free Text	
Notes	Free Text	

My Fitness

This section collects information about physical activity. Docket™ also supports data from wearable devices such as Bluetooth-enabled glucometers, pedometers, and scales.

Question	Answer Type	Notes
How do you stay active?	Multiple Selection	Conditional
How many days a week are you active?	Minus/Plus	Limited to Seven

For how long are you active?	Single Selection	
Do you wish you were more active?	Binary	
Do you experience difficulties that prevent you from being more active?	Binary	
If so, please explain.	Free Text	

My Lifestyle

Information related to alcohol, tobacco, recreational drugs, sexual wellness, and behavioral health is curated here.

Lifestyle

Question	Answer Type	Notes
Do you drink alcohol?	Binary	Conditional
How many times a week?	Single Selection	
On average, how many beverages?	Single Selection	
What's your beverage of choice?	Single Selection	
How long as this been true?	Single Selection	
Do you typically drink alone or with friends?	Single Selection	
Was there ever a time when you drank more?	Binary	
Do you use tobacco products?	Binary	Conditional
What kind of tobacco products do you use?	Single Selection	Conditional
How often do you smoke?	Single Selection	
How many times a day?	Single Selection	
How long has this been true?	Single Selection	
Was there a time you used more?	Binary	
Do you currently or have ever used drugs recreationally?	Binary	Conditional
How often, if ever, have you used marijuana/cannabis (hashish, blunts)?	Single Selection	
How often, if ever, have you used synthetic marijuana/cannabis (or Spice, K2)?	Single Selection	
How often, if ever, have you used cocaine (crack, coke)?	Single Selection	
How often, if ever, have you used barbiturates or sedatives (prescription-	Single Selection	

type sleeping pills like Seconal, Ambien, Nembutal, downs, or Yellow Jackets)?		
How often, if ever, have you used tranquilizers (prescription-type drugs like Valium, Librium, Xanax, Ativan, Klonopin)?	Single Selection	
How often, if ever, have you used amphetamines (Adderall, Ritalin, methamphetamines, crystal meth, speed, uppers, ups)?	Single Selection	
How often, if ever, have you used heroin?	Single Selection	
How often, if ever, have you used pain relievers or other opiate-type drugs (codeine, morphine, Demerol, Percodan, Percocet, Vicodin, Oxycontin/oxycodone)?	Single Selection	
How often, if ever, have you used LSD?	Single Selection	
How often, if ever, have you used other psychedelics or hallucinogens like mushrooms, mescaline, or PCP?	Single Selection	
How often, if ever, have you used Ecstasy (MDMA)?	Single Selection	
How often, if ever, have you used club drugs (like Special K, Super K, Ketamine, Liquid G, GHB)?	Single Selection	
How often, if ever, have you used waterpipe smoking (hookah, arghile, shisha)	Single Selection	
Do you have any concerns about this drug use?	Binary	
Would you like to provide any more information?	Free Text	

Sexual Wellness

Question	Answer Type	Notes
I am attracted to:	Single Selection	
I am comfortable with my sexuality…	Single Selection	
Are you currently sexuality active?	Binary	Conditional
What kind of sexual intercourse do you have?	Multiple Selection	
Are you monogamous?	Binary	
What kind of partners do you have?	Single Selection	

How often do you and your partner(s) use protection/contraception?	Ternary	
What kind of protection/contraception do you and your partner(s) use?	Multiple Selection	
Have you ever felt pressured into sex by your partner?	Quaternary	
Have you ever been sexually assaulted?	Binary	Conditional
Have you already reached out to somebody for help?	Binary	
Would you like to seek council or help from a healthcare professional?	Binary	
When did this happen?	Date Picker	
Is there any more information you would like to communicate to a healthcare professional about this?	Free Text	
Do you have any additional questions or concerns regarding sex or sexual wellness?	Free Text	

Mental Wellness

Questions in this section are prefaced with "During the past 2 weeks…"

Question	Answer Type	Notes
Have you had little interest or pleasure in doing things?	Single Selection	
Have you felt down, depressed, or hopeless?	Single Selection	
Have you had trouble falling asleep, staying asleep, or sleeping too much?	Single Selection	
Have you felt tired or have little energy?	Single Selection	
Is your appetite poor or have you been overeating?	Single Selection	
Have you felt bad about yourself or believed that you're a failure?	Single Selection	
Do you have trouble concentrating on things, such as reading the newspaper or watching television?	Single Selection	
Do you move or speak so slowly that other people could have noticed? Or, are you more fidgety or restless than usual?	Single Selection	

Do you have thoughts that you would be better off dead or of hurting yourself in some way?	Single Selection	
How often do you feel nervous, anxious, or on edge?	Single Selection	
How often are you not able to stop or control?	Single Selection	
How often do you worry too much about different things?	Single Selection	
Do you have trouble relaxing?	Single Selection	
How often do you feel restless and unable to sit still?	Single Selection	
How often do you become easily annoyed or irritable?	Single Selection	
How often do you feel afraid as if something awful might happen?	Single Selection	
Are you concerned about depression?	Binary	
Does anyone in your family suffer from depression?	Binary	Conditional
Who [in your family suffers from depression]?	Free Text	
Are you concerned about anxiety?	Binary	
Does anyone in your family suffer from anxiety?	Binary	Conditional
Who [in your family suffers from anxiety]?	Free Text	

My Health

Allergies, hospitalizations, immunizations, medical conditions, and travel are outlined here. Female patients report OBGYN-related information here as well.

Question	Answer Type	Notes
Are you currently being treated for any conditions?	Binary	Conditional
Add Current Health Condition	Actionable	
Condition name:	Free Text	
When were you diagnosed?	Date Picker	
Add Physician [who treats this patient's condition]	Actionable	
First Name [of physician]	Free Text	Formatted ("Dr.")
Last Name [of physician]	Free Text	
Specialty	Single Selection	
Street Address	Free Text	

Street Address Line 2	Free Text	
Zip	Free Text	Formatted
Phone Number	Number Pad	Formatted
Email Address	Free Text	
Have you been treated for other conditions in the past?	Binary	Conditional
Add Past Health Condition	Actionable	
Condition name:	Free Text	
When were you diagnosed?	Date Picker	Formatted
When did you fully recover?	Date Picker	Formatted
Add Physician [who treated this patient's condition]	Actionable	
First Name [of physician]	Free Text	Formatted ("Dr.")
Last Name [of physician]	Free Text	
Specialty	Single Selection	
Street Address	Free Text	
Street Address Line 2	Free Text	
Zip	Free Text	Formatted
Phone Number	Number Pad	Formatted
Email Address	Free Text	
Have you ever had surgery?	Binary	Conditional
Add Surgery	Actionable	
Which procedure?	Free Text	
When was the procedure?	Date Picker	
Were there any complications during the procedure?	Free Text	
Add surgeon [who performed this operation]	Actionable	
First Name [of surgeon]	Free Text	Formatted ("Dr.")
Last Name [of surgeon]	Free Text	
Specialty	Single Selection	
Street Address	Free Text	
Street Address Line 2	Free Text	
Zip	Free Text	Formatted
Phone Number	Number Pad	Formatted
Email Address	Free Text	
Have you ever been hospitalized for any condition that did not require surgery?	Binary	Conditional
What was the reason for the hospitalization?	Free Text	
When was the hospitalization?	Date Picker	

Where were you hospitalized on this occasion?	Free Text	
Do you require mobility assistance	Single Selection	
Have you ever received a blood transfusion?	Ternary	
Do you have any allergies? (including latex, dyes, iodine, other drugs, and/or food)?	Binary	Conditional
Add Allergy	Actionable	
What are you allergic to?	Free Text	
What is the reaction?	Single Selection	
[Have you received an immunization for] Pneumococcal (for pneumonia)?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	
[Have you received an immunization for] Hepatitis A?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	
[Have you received an immunization for] Hepatitis B?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	
[Have you received an immunization for] Tetanus/Diphtheria (within the last 10 years)?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	
[Have you received an immunization for] Influenza (flu)?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	
[Have you received an immunization for] Measles?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	
[Have you received an immunization for] Mumps?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	

[Have you received an immunization for] Rubella?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	
[Have you received an immunization for] Polio?	Binary	Conditional
Year?	Single Selection	
Month? (if known)	Single Selection	
Add Other Immunization	Actionable	
Immunization (name):	Free Text	
Year?	Single Selection	
Month (if known)?	Single Selection	
Have you ever traveled or lived in a foreign country?	Binary	Conditional
Add Travel	Actionable	
Where?	Free Text	
When?	Date Picker	
Are you Pre-menopausal or Post-menopausal?	Binary	Conditional
How often are your periods?	Single Selection	
Are your periods normal	Single Selection	
How many days do your periods last?	Single Selection	
Do you regularly spot or bleed between periods?	Binary	
Do you have menstrual pain/cramping?	Binary	
What medications do you take for this?	Free Text	
Do you think there is a problem with your periods?	Binary	
If yes, explain.	Free Text	
Do you use birth control?	Binary	
Birth control methods:	Multiple Selection	
Have you been vaccinated against the HPV virus?	Single Selection	
Have you ever had any of the following [conditions]?	Multiple Selection	
Is there a chance you may be pregnant?	Binary	
Have you ever been pregnant?	Binary	Conditional
How many times have you been pregnant?	Single Selection	
How many children do you have?	Single Selection	

Have you ever lost a pregnancy?	Binary	Conditional
How many?	Single Selection	
Have you ever terminated a pregnancy?	Binary	Conditional
How many?	Single Selection	
Would you like to provide any additional information or voice any concerns?	Free Text	
When was your last period?	Date Picker	Formatted
Have you ever received Hormone Replacement Therapy?	Binary	
Why or why not [have you received Hormone Replacement Therapy]?	Free Text	
If so, for how long?	Free Text	
Are you experiencing any vaginal bleeding?	Binary	

My Family

Family medical histories are reported here.

Question	Answer Type	Notes
What medical conditions does your mother have?	Single Selection	Conditional
Add Condition	Actionable	
Condition:	Free Text	
How old was your mom at diagnosis?	Single Selection	
What medical conditions does your father have?	Single Selection	Conditional
Add Condition	Actionable	
Condition:	Free Text	
How old was your father at diagnosis?	Single Selection	
Do you have siblings?	Binary	Conditional
Are your siblings treated for any medical conditions?	Binary	Conditional
Add Sibling	Actionable	
What year was your sibling born?	Single Selection	
What is the medical condition?	Free Text	
How old was your sibling when diagnosed?	Single Selection	
Do your grandparents have medical conditions they are treated for?	Binary	Conditional
Is your paternal grandmother alive?	Binary	Conditional
Add Medical Condition	Actionable	

What medical condition does she have?	Free Text	
Approximately what age was the diagnosis?	Single Selection	
What was her age of death?	Single Selection	
Is your paternal grandfather alive?	Binary	Conditional
Add Medical Condition	Actionable	
What medical condition does he have?	Free Text	
Approximately what age was the diagnosis?	Single Selection	
What was his age of death?	Single Selection	
Is your maternal grandmother alive?	Binary	Conditional
Add Medical Condition	Actionable	
What medical condition does she have?	Free Text	
Approximately what age was the diagnosis?	Single Selection	
What was her age of death?	Single Selection	
Is your maternal grandfather alive?	Binary	Conditional
Add Medical Condition	Actionable	
What medical condition does he have?	Free Text	
Approximately what age was the diagnosis?	Single Selection	
What was his age of death?	Single Selection	
Are there other medical conditions that run in your family?	Binary	Conditional
Add Medical Condition	Actionable	
What is the medical condition?	Free Text	
Who is affected?	Multiple Selection	