# PRE-VISIT QUESTIONNAIRE

**Name:** 

## TODAY’S VISIT

What are you hoping to accomplish today? ______________________________

Is there anything else you’d like to work on to improve your health? ______________________________________________________

### If you have one of the following conditions, please answer:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
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<tr>
<td>High blood pressure</td>
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<tr>
<td>High cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
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</tbody>
</table>

Any problems with medications? □ Yes □ No

Home glucose readings ________________________________

Home BP readings ________________________________

### BETWEEN VISITS

Have you been to the ER, hospital, or another doctor since last seen here? □ Yes □ No

Please explain: ______________________________________

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## LIFESTYLE

### Exercise:

What do you do? ________________________________

How long? __________ How often? __________

Can you walk a block or climb a flight of stairs without getting short of breath? □ Yes □ No

### Smoking:

How much do you smoke? ________________________________

Are you interested in quitting? □ Yes □ No

### Alcohol:

How many drinking days do you have per week? ______

On average how many drinks per drinking day? ______

Have you had more than 4 drinks in a day in the past 3 months? □ Yes □ No

Are you or others concerned about your drinking? □ Yes □ No

### Falls:

Have you fallen in the past year? □ Yes □ No

Do you have problems with walking or balance? □ Yes □ No

### Safety:

Are you in a relationship where you feel unsafe or have been hurt? □ Yes □ No

Do you regularly wear a seatbelt? □ Yes □ No

### HIV testing:

Would you like HIV testing? □ Yes □ No

(If yes, please tell the nurse.) HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of injection drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

### Caffeine:

How much caffeine do you consume per day? (e.g., coffee, tea, chocolate, soda) ________________________________

### Birth control method (if applicable):

### Sleep:

Do you stop breathing during sleep or have concerns about sleep apnea? □ Yes □ No

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## Depression screen:

Over the last 2 weeks have you been bothered by little interest or pleasure in doing things, or feeling down, hopeless, or depressed? □ Yes □ No

## Medications:

Do you have any trouble taking any of your medications? □ Yes □ No

If so, what sort of trouble? ________________________________

## Bladder control:

Do you lose control of your urine to the point you would like to know how to treat it? □ Yes □ No

## End-of-life care:

Do you want to discuss end-of-life issues? □ Yes □ No

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## UPDATE

Has anything new come up in your family history? (new illness among blood relatives) ________________________________

Have you developed any new drug allergies? ________________________________

Are you experiencing any of the following?

### Constitutional symptoms:

- fever
- weight loss
- extreme fatigue

### Eyes:

- double vision
- sudden loss of vision

### Ears, nose, mouth, and throat:

- sore throat
- runny nose
- ear pain

### Cardiovascular:

- chest pain
- palpitations

### Respiratory:

- cough
- wheezing
- shortness of breath

### Gastrointestinal:

- nausea
- vomiting
- abdominal pain
- constipation
- diarrhea
- blood in stools

### Genitourinary:

- irregular menses
- vaginal bleeding after menopause
- frequent or painful urination
- bloody urine
- impotence

### Skin:

- rash
- changing mole

### Sleep:

- snoring
- difficulty sleeping

### Neurological:

- headache
- persistent weakness or numbness on one side of the body
- falling

### Musculoskeletal:

- joint pain
- muscle weakness

### Psychiatric:

- depression
- anxiety
- suicidal thoughts

### Endocrine:

- excessive thirst
- cold or heat intolerance
- sweating
- cleaning

### Hematologic:

- unusual bruising or bleeding
- enlarged lymph nodes

### Allergic:

- hay fever

Please identify any issues above which are new or that you specifically want to address.

### If you need help between appointments, please call our office at (______) ______-__________

Our goal is to see you the day you call in or the next day. It is helpful if you call first thing in the morning.

One of our nurses will help you decide if you need to be seen and if any tests are needed prior to your appointment.