## 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:**

**Diabetes:** Any problems with medications? ☐ Yes ☐ No
Home glucose readings _____

**High blood pressure:** Any problems with meds? ☐ Yes ☐ No

Home BP readings _____

**High cholesterol:** Any problems with meds? ☐ Yes ☐ No

**Depression:** Any problems with meds? ☐ Yes ☐ No

Any suicidal thoughts? ☐ Yes ☐ No

### BETWEEN VISITS

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

Please explain: _____

_____

### 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 interesting 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

**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

### 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 ☐ breast mass

**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.

Family Practice Management

IVANKA A. VASSILEVA, M.D.

PATIENT:_____DOB:_____TODAY'S DATE_____

# Depression Screening

| Over the past two weeks, how often have your been bothered by any of the following problems? | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things? | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed, or hopeless? | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling or staying asleep, or sleeping too much? | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy? | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite or overeating? | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down? | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television? | ☐ | ☐ | ☐ | ☐ |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual? | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? | ☐ | ☐ | ☐ | ☐ |
| 10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | ☐ | ☐ | ☐ | ☐ |

IVANKA A. VASSILEVA, M.D.

PATIENT:_____DOB:_____TODAY'S DATE_____

# Fall Risk Assessment

1. Have you fallen in the past year? ☐ Yes ☐ No
2. Are you afraid of falling? ☐ Yes ☐ No
3. Do you use assistive equipment to ambulate? ☐ Yes ☐ No
4. Do you ever feel dizzy or lightheaded? ☐ Yes ☐ No
5. Do you have trouble getting up from a chair? ☐ Yes ☐ No
6. Do you have trouble stepping up or down curbs or steps? ☐ Yes ☐ No
7. Do you need to steady yourself by leaning on someone/something?
   (i.e. walls, grocery cart, furniture) ☐ Yes ☐ No
8. Do you see well: during the day? ☐ Yes ☐No
   at night? ☐ Yes ☐ No
9. Do you have any of the following falls risks in or around your house:
   a) Throw rugs ☐ Yes ☐No
   b) Pets: ☐ Yes ☐ No
   (if yes, indicate type(s): _____total number of pets_____)
   c) Poor lighting: ☐ Yes ☐ No
   d) Cluttered pathways: ☐ Yes ☐No
   e) Improper footwear: ☐ Yes ☐ No
   f) Tripping hazards (i.e. $O^2$ tubes; electrical cords): ☐ Yes ☐ No
   g) Other: _____
10. If you have fallen in the past year, what were the circumstances:
    [if no falls in past year: ☐ N/A]
    a.) What were you doing when you fell: _____
    b.) Did you lose consciousness? ☐ Yes ☐ No
    c.) Were you lightheaded/dizzy prior to fall? ☐ Yes ☐ No
    d.) Did you need help to get up from the fall? ☐ Yes ☐ No