GERIATRIC TREATMENT RESOURCES LLC

Pre-Visit Questionnaire: Initial Visit

Date:

1. **Name**:

2. **Address**:
   Street Address/ Apt. Number

   City/State Zip

3. **Phone**: (_____) **Email:**_____

4. **What is your date of birth?** _____/_____/
   month day year

5. **Sex**: 1)___Male 2)___Female

6. **Who filled out this form?**
   *Relationship, if other than patient
   Phone number: (_____)

7. **Who has been your previous primary doctor?**
   Name:
   Address:

   Phone number: (_____)
   Fax Number: (_____)

8. **Do you plan to continue to be followed by this doctor?**
   1)___NO 2)___YES 3)___Not sure

Name:_____ Date of Birth _____

PAST MEDICAL HISTORY

9. Which medical conditions do you have or have you had in the past?

(Check all that apply)

I. EYE & EAR PROBLEMS

a)____Cataracts
b)____Glaucoma
c)____Macular degeneration of the eye
d) ____ Hearing loss/hearing aid
e) ____Other, specify:

II. HEART PROBLEMS

a)____Heart attack: Year_____
b)____Heart failure
c)____High blood pressure
d)____Irregular heartbeat (Arrhythmias)
e)____ High cholesterol
f) ____Other, specify:

III. LUNG PROBLEMS

a)____Asthma
b)____Bronchitis
c) _____Emphysema
d) ____Other, specify:

IV. BONE & JOINT PROBLEMS

a)____Arthritis
b)____Osteoporosis
c)____Fractured hip, wrist or spine
(circle which one)
d) ____ Gout
e) ____Other, specify:

V. GLAND PROBLEMS

a)____Diabetes
b)____Thyroid overactive (high)
c) _____ Thyroid underactive (low)
d) ____Other, specify:

VI. KIDNEY & URINARY TRACT PROBLEMS

a)____Kidney disease
b)____Prostate disease
c)____Frequent bladder or kidney infections
d)____Urinary incontinence
e) ____Other, specify:

VII. GASTROINTESTINAL PROBLEMS

a)____Ulcers
b)____Heartburn/Hiatal hernia
c)____Diverticulosis
e)____Hepatitis
f)____Polyps
g)____Gallbladder disease

d)____Liver disease/Cirrhosis

h)____Other, specify:

VIII. NERVOUS SYSTEM PROBLEMS

a)____Stroke

b)____Dementia or Alzheimer's Disease

c)____Parkinson's Disease

d)____Epilepsy or Seizures

e) ____Other, specify:

IX. OTHER HEALTH PROBLEMS

a)____Allergies, specify_____

b)____Anemia

c)____Hernia

d)____Thrombosis (blood clots)

e)____Cancer, of what ?

f)____Depression

g)____Sexual function problems, specify

h) ____ Hepatitis C screening

i)____Other, specify:

10. List Surgeries (Operations).

DATE	SURGERY (OPERATIONS)

11. List Other Hospitalizations.

DATE	REASON

Name:_____ Date of Birth _____

12. Do you have any drug allergies?

1)_____NO

2)_____YES. → If YES, specify below

NAME OF DRUG	**REACTION**

13. List all medicines that you use. (Prescriptions, Non-Prescriptions, Natural Products)

Current medications used **regularly**	What strength?	How do you use it? (How many? How many times a day?)

Name:_____ Date of Birth _____

SOCIAL HISTORY

14. With whom do you live? (check one)

a)_____Alone

b)_____Spouse or partner

c)_____Child or other family member

d) ____ Others, not family

e) _____Other, specify:

15. Which of the following best describes your residence? (check one)

a)_____Single-family house

b)_____Condo or apartment

c)_____Live with other in their home, condo or apartment

e)_____Board and care/residential care facility

f)_____Nursing Home

g) ____Assisted Living Facility

16. Are you currently (check one)

a)_____Married

b)_____Divorced/Separated

c)_____Widowed

d) ____ Single/Never married

e) _____Living with Significant Other:

17. How many children do you have? _____

Are you in regular contact with your children? Yes_____ No_____

18. How much school did you complete? (check one)

a)_____Less than 6th grade

b)_____Less than high school graduate

c)_____High school graduate

d) ____ Some college

e) _____College graduate

f) _____More than College graduate

19. What has been your principal occupation?

20. Are you currently (check one)

a)_____Retired/Not working

b)_____Working part-time

c) ____ Working full-time

21. Do you <u>employ</u> someone to provide care or help you in your home?

1)___NO

2)___YES.→ If YES, **How many hours a day and how many days a week is your paid helper available for you?**

_____ hours a day and_____days a week

Is this sufficient to meet your needs?

1)___NO 2)___YES

22. Do you get help from a family member or friend in your home?

1)___NO

2)___YES.→ If YES, **approximately how many hours a day and how many days a week is your family member or friend available for you?**

_____ hours a day and_____days a week

Is this sufficient to meet your needs?

1)___NO 2)____YES

23. Who would you call if you were sick and needed help?_____

24. Do you provide care for a family member?

1)___NO 2)___YES

25. Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

a)____Daily

b)____Almost daily (4 to 6 times a week)

c)____1 to 3 times a week

d) ____ Less than 1 time a week

e) ____Never

26. If you drink alcohol, has anyone ever been concerned about your drinking?

1)___NO

2)___YES

27. Have you ever smoked cigarettes?

1)___NO

2)___YES.→ If YES, **Are you now smoking?**

a)____no. If no,

1. How many years ago did you quit?

2. For how many years did you smoke?
3. How much did you smoke?_____packs per day

b)____yes. If yes,

1. How many years have you smoked?
2. How much do you smoke? packs per day

FAMILY HISTORY

28. Have any members of your family had any of the following conditions? Check all that apply)

a)____Dementia or Alzheimer's Disease
b)____Cancer, of what?
c)____Heart disease
d)____Stroke
e)____Diabetes
f)____Depression
g)____None of these
h)____Other, specify:

PLANNING FOR FUTURE HEALTH CARE

29. Would you like to discuss Advance Care Planning (ACP) today?

1)____NO 2)____YES (Please be advised that there may be a copayment / deductible applicable for this discussion as per Medicare guidelines)

30. Do you have a medical Durable Power of Attorney?

1)____NO 2)____YES (If yes, please bring a copy)

31. Do you have a living will?

1)____NO 2)____YES (If yes, please bring a copy)

32. Have you completed a POLST form? ____No,_____yes (would you like to complete it today, #29 will apply)

33. We want to know if you need help with any of the following, and who helps you. Fill out for each task .

TASK	**DON'T NEED HELP**	**NEED HELP**	**IF YOU NEED HELP, WHO HELPS? (Name and Relationship)**
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			

Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money/financial affairs			
Doing laundry			
Doing house work			
Shopping for groceries			
Driving			
Doing 'handyman' work			
Climbing a flight of stairs			
Getting to places beyond walking distance			

34. To be certain that we've covered everything, during <u>the last three months</u>, have you had any of the following symptoms or problems? (check all that apply)

I. GENERAL PROBLEMS

a)____Weight loss

b)____Weight gain

c)____Fevers

d)____Chills

e)____Sweats

f)____Cold or Flu

g)____Change of appetite

II. EYES

a)____Trouble seeing

b)____Eye pain

c) ____ Dry eyes

III. EAR, NOSE, MOUTH, THROAT

a)____Trouble hearing

b)____Ear pain or itching

c)____Sinus problems

d) ____ Nose bleeds

f) ____Teeth problems

g) ____Hoarseness

h)____Mouth Sores

i) ____Allergies

e) ____Sore throat

IV. HEART PROBLEMS

a)_____Chest pain or tightness

b)_____Rapid or irregular heart beat

c) ____ Swelling of feet

V. LUNG PROBLEMS

a)_____Persistent cough

b)_____Difficulty breathing or shortness of breath

c) ____ Coughing up blood

d)_____Wheezing

VI. DIGESTION PROBLEMS

a)_____Difficulty swallowing

b)_____Frequent indigestion or stomach ache, heartburn

c)_____Frequent nausea or vomiting

d)_____Change in bowel habits

e)_____Black bowel movement or bleeding from rectum

f)_____Frequent diarrhea

g)_____Persistent constipation

VII. BONE AND JOINT PROBLEMS

a)_____Leg pain on walking

b)_____Back or neck pain

c)_____Joint pain or stiffness

d) ____ Foot problems

e) _____Falls ,When was your last fall_____

VIII. BRAIN AND NERVOUS SYSTEM PROBLEMS

a)_____Frequent headaches

b)_____Frequent dizzy spells

c)_____Passing out or fainting

d)_____Falls

e)_____Paralysis, leg or arm weakness

f)_____Numbness or loss of feeling

g)_____Serious problem with memory or difficulty thinking

h) ____ Tremor or shaking

i)_____Problems with sleep

X. MOOD/SADNESS PROBLEMS

a)_____Depression b)_____Anxiety

XI. GYNECOLOGY PROBLEMS

a)_____Vaginal bleeding b)_____Breast lumps or discomfort

c)_____Vaginal discharge

XII. KIDNEY & URINARY TRACT PROBLEMS

a)____Urination at night _____(How many times)

b)____Frequent urination c)_____Painful urination

d)____Difficulty starting or stopping urination

e)____Loss of urine or getting wet. If yes, 6 or more times in last year?

XIII. SKIN PROBLEMS

a)____Rash b)_____Sores c)_____Itching

XIV. MISCELLANEOUS

a)____Excessive thirst b)____ Feel too hot or too cold c) _____Problems with sexual function

If you have had none of the above problems listed in question 32 during the past 3 months, check here_____

HEALTH MAINTENANCE

35. Have you ever had an examination of your bowel with a scope (Circle which one: sigmoidoscopy or colonoscopy)?

1)____NO 2) ___ YES. → If YES, When did you have your most recent sigmoidoscopy or colonoscopy ____(year)

36. Have you had a hearing test within the last two years? Yes_____ No_____

37. Have you had an eye exam within the past year? Yes_____ No_____

38. In the past 12 months, have you had a test for blood in your stool (three cards at home)?

1)____NO 2)____YES

39. Have you seen a dentist in the last year? YES_____ NO_____

40. Have you ever had the Pneumovax vaccine (a shot to prevent pneumonia)?

1)____NO 2)____YES→ If YES, in what year ____.

Prevnar 13 Vaccine _____

41. Have you ever had a tetanus shot?

1)____NO 2)____YES.→ If YES, in what year did you have your last tetanus booster?_____(year)

42. Have you had a flu shot this season, (October-February)? 1)_____NO 2)_____YES

43. Have you had a Shingles vaccine ? 1)____NO 2) _____ YES

44. Do you always wear a seatbelt when you ride in a car? 1)_____NO 2)_____YES

45. Do you currently participate in any regular activity to improve or maintain your physical fitness? (either on your own or in a formal class)

1)_____NO

2)_____YES.→ If YES, **what you do currently.**

Men proceed to question 46; women skip to question 48.

QUESTIONS FOR MEN ONLY

(After completing question 44 please go to question 49)

46. Have you ever had a prostate exam (rectal exam)?

1)____NO

2)____YES.→ If YES, **When did you have your most recent prostate exam?**____(year)

47. Have you ever had a blood test to look for cancer of the prostate (PSA)?

1)_____NO

2)_____YES.→ If YES, **When did you have your most recent blood test to look for prostate cancer?**

_____(year)

QUESTIONS FOR WOMEN ONLY

48. Do you perform breast self-exam (BSE) once a month? 1)____NO 2)____YES

Name:_____ Date of Birth _____

49. Have you ever had a mammogram?

1)____NO

2)____YES.→ If YES, When was your last mammogram _____

50. Have you had a hysterectomy (surgical removal of the uterus)?

1)____YES

2)____NO.→ If NO, When was your last Pap smear/pelvic examination_____

51. Are you enrolled in chronic care management program with any Physician:

Yes_____, No_____.

Please review on cms.gov the chronic care management patient resources and discuss with your physician to see if you are eligible for these services.

52. Do you have any other health problems that you would like your doctor to know about before your visit?

Signature of patient/ POA

Address: _____

_____

_____

THANK YOU FOR COMPLETING THIS FORM.