Name:_____ DOB:_____ Date of Visit:_____

Patient Questionnaire

Social History

☐ Yes ☐ No Do you eat a healthy balanced diet with minimal salt and bad fats?
For Example:
Balanced Diet = Combination of fruits, vegetables, grains, low-fat dairy each day
Minimal Salts = Less than one teaspoon per day
Bad Fats = Fried Food, Fast Food, packaged foods from a box

☐ Yes ☐ No Have you had any unintentional weight loss in the past 6 months?

If so, what is the amount of your recent weight loss: _____ lbs.

Malnutrition

The responses to the following questions should consider the patient response and provider assessment:

☐ Yes ☐ No Inadequate calorie intake?

☐ Yes ☐ No Loss of muscle mass?

☐ Yes ☐ No Loss of fat beneath skin (subcutaneous fat)?

☐ Yes ☐ No Localized or generalized fluid accumulation?

☐ Yes ☐ No Diminished functional status?

Smoking History

What is your history of smoking cigarettes?

☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

If Current Smoker or Former Smoker, how many pack years? (packs per day x number of years smoked)

☐ Less than 30 pack years ☐ Greater than 30 pack years

If yes, you used to smoke, when did you stop smoking cigarettes?

☐ Stopped smoking greater than 15 years ago ☐ Stopped smoking less than 15 years ago

Drug History

☐ No History of Illegal Drug Use (Prescription or Street Drugs)

☐ Illegal Drug Use (Prescription and/or Street Drugs) (Current or in Remission)

If Illegal Drug Use, please select drug(s) below:

☐ Cocaine	☐ Other Stimulant
☐ Opioid	☐ Hallucinogens
☐ Cannabis	☐ Inhalants
☐ Sedative, Hypnotic or Anxiolytic	☐ Other Psychoactive Substances

If any drug(s) selected, please select one of the following:

☐ Social Use ☐ Abuse ☐ Dependency (Current) ☐ Dependency (Remission)

If any drug(s) selected, please select if applicable:

☐ Complications (Mood, Psychotic, Sleep, Anxiety, Sexual or Unspecified Disorders)

Alcohol History

☐ No Current Use of Alcohol

	Select if applicable in addition to use, abuse or dependency:
☐ Social Alcohol Use	☐ Complications (Mood, Psychotic, Sleep, Anxiety, Sexual or Unspecified Disorders)
☐ Alcohol Abuse	☐ Complications (Mood, Psychotic, Sleep, Anxiety, Sexual or Unspecified Disorders)
☐ Alcohol Dependency (Current)	☐ Complications (Mood, Psychotic, Sleep, Anxiety, Sexual or Unspecified Disorders)
☐ Alcohol Dependency (In Remission)	☐ Complications (Mood, Psychotic, Sleep, Anxiety, Sexual or Unspecified Disorders)

Women:

☐ Yes ☐ No — Do you drink (7 or more alcoholic drinks per week or 3 OR more per episode of drinking?

Men:

☐ Yes ☐ No — Do you drink 14 or more alcoholic drinks per week OR 4 or more per episode (for men)?

Self-Assessment

Considering your age, how would you describe your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How much difficulty, if any, do you have walking a ¼ mile which is about 2 or 3 blocks?

☐ No Difficulty At All
☐ A Little Difficulty
☐ Some Difficulty
☐ A Lot Of Difficulty
☐ Not Able To Do It

In the past 7 days, how many days did you exercise?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

☐ Yes ☐ No ☐ Unknown Have you been to the dentist in last 12 months?

Depression Assessment

☐ Yes ☐ No Over the past 2 weeks, have you felt down, depressed, or hopeless?

☐ Yes ☐ No Over the past 2 weeks, have you felt little interest or pleasure in doing things?

☐ Yes ☐ No Are you taking any depression medications?

Fall Risk & Home Safety

☐ Yes ☐ No Do you always fasten your seat belt when you are in a car?

☐ Yes ☐ No Do you have any problems with your hearing?

☐ Yes ☐ No Do you have a problem with balance?

☐ Yes ☐ No Do you have a problem walking?

☐ Yes ☐ No A fall is when your body goes to the ground without being pushed. Have you fallen in the past 12 months?

If Yes to Fall:

☐ Yes ☐ No Were you injured from the fall?

☐ Yes ☐ No Have you had more than one fall?

Activities of Daily Living Scale

☐ Yes ☐ No In the past 7 days, did you need help to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, getting in or out of bed or a chair, or using the toilet?

If yes, check all that apply:

☐ Eating ☐ Getting dressed

☐ Bathing ☐ Walking

☐ Getting in and out of bed/chair

☐ Using the toilet

☐ Yes ☐ No In past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking medications?

Review of Symptoms

General

☐ Yes ☐ No Do you have increasing or worsening weakness or tiredness that is new to you within the last year?

Please rate your pain by marking the box beside the number that best describes your pain at its **worst** in the last 24 hours.

Pain location_____ Pain characteristics_____

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

No Pain Pain As Bad As You Can Imagine

Please rate your pain by marking the box beside the number that best describes your pain at its **least** in the last 24 hours.

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

No Pain Pain As Bad As You Can Imagine

Please rate your pain by marking the box beside the number that best describes your pain on the **average**.

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

No Pain Pain As Bad As You Can Imagine

Please rate your pain by marking the box beside the number that tells how much pain you have **right now**.

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

No Pain Pain As Bad As You Can Imagine

Vision

☐ Yes ☐ No Have you had any recent changes in your vision?

Respiratory/Pulmonary (Lungs)

☐ Yes ☐ No Have you recently had trouble breathing?

☐ Yes ☐ No Do you have a persistent cough that will not go away?

Cardiac (Heart)

☐ Yes ☐ No Do you ever have chest pain, tightness or heaviness in your chest?

☐ Yes ☐ No Do you ever feel short of breath with daily activities such as dressing, showering/bathing, doing laundry, shopping, or walking?

☐ Yes ☐ No Do you have difficulty breathing when lying down flat?

☐ Yes ☐ No Do your legs swell?

☐ Yes ☐ No Do you wake up at night feeling smothered, unable to breathe or drowning that causes you to sit upright?

Vascular (Arteries, Veins)

☐ Yes ☐ No Do you have numbness/tingling in your arms or legs?

☐ Yes ☐ No When walking, do you ever have pain in the back of your legs (calves) that interferes with your lifestyle (example: not able to exercise, not able to walk)?

☐ Yes ☐ No Do you have pain in your legs that gets more sever when your legs are elevated and the pain diminishes when your legs are in a dependent position (example sitting on bed with legs dangling)?

Musculoskeletal (Muscles, Bones, Tendons, Ligaments)

☐ Yes ☐ No Do you have increasing or worsening pain in your joints that is new to you within the last year? (back, neck, hips, knees, shoulders or hands)

Bladder

☐ Yes ☐ No Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine?

If yes, how much of a problem was the urine leakage for you?

☐ A Big Problem ☐ A Small Problem ☐ Not A Problem

Draw A Clock: