Pre-Visit Questionnaire
Iris Cantor-UCLA Women's Center
Menopause or Osteoporosis Consultation

Thank you for completing this form before your visit. It will allow me to perform the most complete evaluation possible when you come in. Your time and effort is much appreciated. I look forward to meeting you. ~ Dr. Greendale

SECTION A: IDENTIFYING INFORMATION

1. **Date form completed:** _____

2. **Name of patient:** _____

3. **Street address:** _____
_____

4. **Phone**: (_____) _____

5. **Date of birth:**_____/_____/_____
month day year

6. **Sex**: ☐ Female ☐ Male

7. **Who filled out this form?** ☐ Self ☐ Other (please give name below)
Name:_____ Phone number: (_____)_____
If other person completed form, what is relationship to patient?
☐ Spouse ☐ Child ☐ Friend ☐ Other (specify):

8. **Who is your primary care doctor?**
Name: _____
Address (include zip code): _____
_____
Phone number: (_____)_____

9. Do you want a copy of your consultation sent to any other doctors?

□ No □ Yes… If yes, please list names and address of each doctor below.

Name: _____

Address (include zip code): _____

_____

Name: _____

Address (include zip code): _____

_____

SECTION B: PAST & CURRENT MEDICAL & SURGICAL HISTORY

Major Medical Conditions

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

a. EYE & EAR

□ Macular degeneration □ Cataracts □ Glaucoma

□ Hearing loss/hearing aid □ Other (specify):

b. HEART

□ Heart attack, year: □ Heart failure □ Hypertension

□ Aortic stenosis □ Heart valve problem □ Angina

□ High cholesterol □ Pacemaker □ Atrial fibrillation

□ Irregular heartbeats (arrhythmias)

□ Other (specify):

c. LUNGS

□ Asthma □ COPD/emphysema □ Bronchitis

□ Recurrent pneumonias □ Other (specify):

d. GASTROINTESTINAL TRACT

□ Heartburn/reflux/GERD □ Ulcers □ Irritable bowel

□ Liver disease/cirrhosis □ Hepatitis □ Gallbladder

□ Colon polyps □ Diverticulosis □ Bleeding

□ Constipation □ Hemorrhoids

□ Other (specify):

e. KIDNEY & URINARY TRACT

□ Frequent bladder infections □ Kidney disease □ Enlarged prostate

□ Urinary incontinence □ Kidney stones

□ Other (specify):

f. BONES & JOINTS

□ Fractured bone: (Fill in which bones)_____

□ Arthritis

□ Gout □ Lower back pain □ Osteoporosis

□ Other (specify):

g. ENDOCRINE SYSTEM

□ Thyroid overactive (high) □ Thyroid underactive (low)

□ Diabetes □ Other (specify):

h. NERVOUS SYSTEM

□ Dementia or Alzheimer's disease □ Parkinson's disease

□ Stroke □ Epilepsy or seizures

□ Neuropathy/nerve damage □ Depression

□ Anxiety □ Other (specify):

i. OTHER HEALTH PROBLEMS

□ Thrombosis/blood clots: □ In the leg □ In the lung □ Anemia

□ Syncope (loss of consciousness) □ Hernia

□ Cancer: □ Breast □ Prostate □ Colon/Rectum □ Lung □ Skin

□ Other : _____

Allergies to Medicines

11. Do you have any drug allergies? □ No □ Yes…If yes, please list name of drug and specify reaction.

Drug: _____ □ Rash □ Shortness of Breath □ Nausea □ Other _____

Drug: _____ □ Rash □ Shortness of Breath □ Nausea □ Other _____

Drug: _____ □ Rash □ Shortness of Breath □ Nausea □ Other _____

Drug: _____ □ Rash □ Shortness of Breath □ Nausea □ Other _____

Current Medications

12. Please list all medicines that you use. (Include prescription, non-prescription [including vitamins and minerals] and natural products; provide doses of each.)

Current medications	What strength?	How do you use it? (How many? How many times a day?)
Example: Tylenol	500 mg.	1 pill 3 times a day

Surgical History

13. Please list all surgeries you have had.

Name of surgery and reason for surgery	Date

SECTION C: FAMILY HISTORY

14. Have any members of your family had any of the following conditions?

□ Dementia or Alzheimer's disease □ Heart disease □ Stroke

□ Diabetes □ Depression

□ Cancer: □ Breast □ Prostate □ Colon □ Lung □ Other cancer (specify):

□ Other medical condition (specify):

15. Did either your mother or father fracture their hip?

□ No □ Yes…If yes, specify mother and/or father and how fracture occurred:

_____

SECTION D: SOCIAL AND FUNCTIONAL HISTORY

Living Situation and Supportive Care

16. With whom do you live? (Check all that apply.)

□ Alone □ Spouse or Partner □ Child

□ Others (specify):

17. Which of the following best describes your residence? (Check one)

□ Single-family house □ Condo □ Apartment

□ Board & care/Assisted living □ Other (specify):

18. You are currently (check one):

□ Single/Never married □ Married □ Divorced/Separated

□ Widowed □ Living with significant other

19. How many children do you have? □ 1 □ 2 □ 3 □ 4 □ 5 or more

20. Do you employ someone to provide health related care or help you in your home?

□ No □ Yes

21. Do you get help from family members or friends in your home?

□ No □ Yes

Education and Occupation

22. Number of years completed

□ Less than 6th grade □ Some high school □ High school graduate

□ Some college □ College graduate □ Graduate school

23. What is/was your principal occupation? _____

24. Current work status:

□ Working full-time □ Working part-time □ Retired/Not working

Health Habits

25. Do you drink alcohol, including beer and wine, or other alcohol?

□ Daily □ 1-3 times a week □ 4-6 times a week

□ Less than once a week □ Never

a) If you drink, how much do you drink at a time? (One drink = 12 oz of beer or 8-9 oz of malt liquor or 5 oz of table wine or 1.5 oz of hard alcohol)

□ 1 drink □ 2 drinks □ 3 drinks □ 4-5 drinks □ 6 or more drinks

26. Have you <u>ever</u> smoked cigarettes? □ No □ Yes…If yes, please continue:

Do you <u>currently</u> smoke cigarettes?

□ Yes…If yes, how many packs per day? □ ¼ □ ½ □ 1 □ 1½ □ 2+

□ No…If no, when did you quit? _____(year)

27. Do you currently participate in any activity to maintain your physical fitness?

□ No □ Yes…if yes, check all that apply and approximate time spent in all activities

□ Walking	□ Swimming	□ Aerobics or exercises classes
□ Dancing	□ Jogging	□ Bicycling or stationary bike
□ Tennis	□ Golf	□ Bowling or boccie
□ Yoga	□ Pilates	□ Other (specify):

Total days per week (add up all activities)	Average amount of activity time per day
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7	□ < 15 min □ 15-30 min □ 30-45 min □ 45-60 min □ 60-90 min □ > 90 min

SECTION E: HEALTH TESTS

28. Have you had any of the following tests done?

Test	Date most recently done	Results
Eye examination		
Hearing test		
Mammogram		
Pap smear		
Bone density test (BMD)*		
**If coming in for an osteoporosis evaluation, please bring copies of all prior BMDs if possible.*		

SECTION F: REVIEW OF SYMPTOMS

29. Have you had a fall in the past year? □ No □ Yes…If yes, please describe the circumstances surrounding the fall:

- Did you trip over something? □ Yes □ No
- Did you have lightheadedness or palpitations prior? □ Yes □ No
- Did you lose consciousness? □ Yes □ No
- Were you injured? □ Yes □ No
- Did you need to see a doctor? □ Yes □ No
- Were you able to get up by yourself? □ Yes □ No

30. Are you afraid of falling? □ No □ Yes

31. Do you use a mobility aid? □ No □ Yes…If yes, which ones?

□ cane □ walker □ wheelchair

32. Please describe whether your health affects your ability to do each of the following:

Activity	No help needed	Help needed	Who helps?
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing or showering			
Walking across the room			
Preparing meals			
Moderately strenuous housework (. e.g., laundry)			
Shopping for groceries			
Driving			
Climbing a flight of stairs			
Getting to places beyond walking distance (e.g. by bus, taxi, or car)			

33. During the <u>past 3 months</u>, have you had any of the following symptoms or problems?

a. GENERAL PROBLEMS

□ Weight loss □ Weight gain □ Fevers

□ Chills □ Sweats □ Change of appetite

b. EYES

□ Trouble seeing □ Eye pain □ Dry eyes

c. EAR, NOSE, MOUTH, THROAT

□ Trouble hearing □ Sore throat □ Allergies

□ Sinus problems □ Teeth problems □ Hoarseness

d. LUNG PROBLEMS

□ Persistent cough □ Coughing up blood □ Wheezing

□ Difficulty breathing or shortness of breath

e. HEART PROBLEMS

□ Chest pain or tightness □ Rapid heart beat

□ Swelling of feet □ Irregular heart beat

f. DIGESTION PROBLEMS

□ Difficulty swallowing □ Abdominal pain

□ Change in bowel habits □ Frequent indigestion or heartburn

□ Frequent nausea or vomiting □ Persistent constipation

□ Frequent diarrhea □ Bleeding from rectum

□ Black bowel movement

g. GYNECOLOGY PROBLEMS

- □ Vaginal bleeding
- □ Breast lumps or discomfort
- □ Vaginal discharge

h. KIDNEY & URINARY TRACT PROBLEMS

- □ Frequent urination
- □ Painful urination
- □ Difficulty starting or stopping urination
- □ Frequent urine infection
- □ Urination at night
  - If yes, how many times each night:_____
- □ Loss of urine
  - If yes:
    - □ Sudden urge to void
    - □ Loss with cough or laughing
    - □ Continuous leakage
    - □ Hard to start urination
    - □ Cannot empty bladder
    - □ Problem getting to toilet

i. BONE AND JOINT PROBLEMS

- □ Leg pain on walking
- □ Back or neck pain
- □ Joint pain or stiffness
- □ Foot problems
- □ Falls

j. BRAIN AND NERVOUS SYSTEM PROBLEMS

- □ Frequent headaches
- □ Frequent dizzy spells
- □ Passing out or fainting
- □ Paralysis, leg or arm weakness
- □ Numbness or loss of feeling
- □ Tremor or shaking
- □ Problems with sleep
- □ Hallucinations
- □ Serious problem with memory or difficulty thinking

k. MOOD PROBLEMS

- □ Depression
- □ Anxiety

l. SKIN PROBLEMS

- □ Rash
- □ Sores
- □ Itching
- □ Easy bruising

m. MISCELLANEOUS

- ☐ Excessive thirst
- ☐ Feel too hot or too cold
- ☐ Problems with sexual function
- ☐ Bleeding problems

34. Please list specific questions that you would like Dr. Greendale to address during your visit.

Thank you again for taking the time to complete this form.