Pre-Visit Questionnaire
Division of Geriatric Medicine
UCLA Healthcare

Thank you for completing this form before your visit. It will allow your doctor to perform the most complete evaluation possible when you arrive for your appointment. Your time and effort is much appreciated.

1. Date form completed: _____/_____/_____
month day year

2. Name of patient: _____

3. Home Address: _____
_____

4. Phone: (_____)_____

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

6. Sex: □ Male □ Female

7. Who filled out this form? □ Self □ Other (please give name below)

Name:_____ Phone number: (___) _____

If other person completed this form, what is the relationship of the person to the patient?

□ Spouse □ Child □ Friend □ Other (specify):

8. Who has been your primary care doctor?

Name: _____

Address:_____

_____

Phone number: (_____)_____

Fax Number: (_____)_____

9. Do you plan to continue seeing the above listed primary care doctor?

□ Yes □ No □ Not sure

PAST MEDICAL HISTORY

10. Which medical conditions do you have now or have you had in the past?
Please check all that apply.

EYE & EAR

- □ Macular degeneration
- □ Cataracts
- □ Glaucoma
- □ Hearing loss/hearing aid
- □ Other (specify): _____

HEART

- □ Heart attack, year: _____
- □ Heart failure
- □ High blood pressure
- □ Aortic stenosis
- □ Heart valve problem
- □ Angina
- □ High cholesterol
- □ Pacemaker
- □ Atrial fibrillation
- □ Irregular heartbeats (arrhythmias)
- □ Other (specify): _____

GASTROINTESTINAL TRACT

- □ Heartburn/reflux/GERD
- □ Ulcers
- □ Irritable bowel
- □ Liver disease/cirrhosis
- □ Hepatitis
- □ Gallbladder disease
- □ Colon polyps
- □ Diverticulosis
- □ Bleeding problems
- □ Constipation
- □ Hemorrhoids
- □ Other (specify): _____

LUNGS

- □ Asthma
- □ COPD/emphysema
- □ Bronchitis
- □ Recurrent pneumonias
- □ Other (specify): _____

KIDNEY & URINARY TRACT

- □ Frequent bladder infections
- □ Kidney disease
- □ Enlarged prostate
- □ Urinary incontinence
- □ Kidney stones
- □ Other (specify): _____

BONES & JOINTS

- □ Gout
- □ Lower back pain
- □ Osteoporosis
- □ Arthritis (indicate location):
  - □ hip
  - □ knee
  - □ shoulder
  - □ back
  - □ hands
- □ Fractured bone (indicate location):
  - □ hip
  - □ spine
  - □ wrist
  - □ Other (specify):
- □ Other (specify): _____

GLANDS

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

□ Diabetes □ Other (specify): _____

NERVOUS SYSTEM

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

□ Epilepsy or seizures □ Neuropathy/nerve damage □ Depression

□ Anxiety□ Other (specify): _____

OTHER HEALTH PROBLEMS

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

□ Syncope (loss of consciousness) □ Hernia □ Anemia

□ Sexual function problems (specify): _____

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

□ Other (specify):_____

List Surgeries (Operations):

□ Heart bypass Date: _____

□ Heart stent placement Date: _____

□ Heart valve replacement…□ Aortic □ Mitral □ Other: Date: _____

□ Pacemaker placement Date: _____

□ Defibrillator/ICD placement Date: _____

□ Tonsils removed Date: _____

□ Appendix removed Date: _____

□ Gallbladder removed Date: _____

□ Knee replacement Date: _____

□ Hysterectomy Date: _____

□ Hip repair due to hip fracture Date: _____

□ Hip replacement not due to hip fracture Date: _____

□ Cataract Date: _____

□ Other Surgeries: (Please list below.)

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

11. List hospitalizations for the last 5 years.

Reason for hospitalization	Year

12. Do you have any drug allergies? □ Yes □ No

If yes, please list name of drug and specify reaction.

	Indicate Reaction			
Name of Drug	**Rash**	**Shortness of Breath**	**Nausea**	**Other (specify)**

13. List all medicines that you use. (Include all Prescription, Non-Prescription, and Natural Products)

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

14. SOCIAL HISTORY

1) With whom do you live?
Please check all that apply

□ Alone

□ Spouse or Partner

□ Child

□ Other family member (specify):
_____

□ Others, not family (specify):
_____

2) Which of the following best describes your residence?

□ Single-family house

□ Condo

□ Apartment

□ Board & care/Assisted living

□ Nursing home

□ Other (specify): _____

3) If living at a facility, please list name of person and the contact number for medical treatment orders:

Name: _____

Phone number: (_____)_____

4) You are presently:

□ Single/Never married

□ Married

□ Divorced/Separated

□ Widowed

□ Living with significant other

5) How many children do you have?

Number:_____

Are you in regular contact with your children? □ Yes □ No

6) How much school did you complete?

□ Less than 8th grade

□ Some high school

□ High school graduate

□ Some college

□ College graduate

□ Graduate school

7) You are presently (check one):

□ Retired/Not working

□ Working part-time

□ Working full-time

8) List your principal occupation and any other significant past occupations.

1._____

2._____

3._____

4._____

5._____

Who would you call if you were sick and needed help? (Check all that apply.)

□ Spouse/Partner
□ Son
□ Daughter
□ Friend
□ Neighbor
□ Other (specify): _____

a) Please list name(s) and phone number(s):

Name: _____ Phone number: (____) _____
Name: _____ Phone number: (____) _____
Name: _____ Phone number: (____) _____

b) Do we have your permission to speak to the person(s) listed above on your behalf?

□ Yes □ No

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

□ Yes □ No

If yes, please indicate the number of hours per day and days per week your paid helper is available to you.

Hours per day	Days per week
List number of hours:	□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

Is this sufficient to meet your needs?

□ Yes □ No

Do you get help from family members or friends in your home? □ Yes □ No

If yes, please indicate the number of hours per day and days per week your family member(s) or friend(s) are available to you.

Hours per day	Days per week
List number of hours:	□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

Is this sufficient to meet your needs?

□ Yes □ No

Do you provide care for a family member?

□ Yes □ No

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

□ Daily

□ A few days a week (specify number of days:_____)

□ Less than once a week

□ Never

a) 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 drinks

□ 5 or more drinks (number:_____)

b) Has anyone ever been concerned about your drinking? □ Yes □ No

Have you <u>ever</u> smoked cigarettes?

□ Yes □ No

If yes:

Do you currently smoke cigarettes?

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

□ No… If no, when did you quit? Year: _____

For how many years did you smoke? Number of years:_____

How many packs per day? □ ¼ □ ½ □ 1 □ 1½ □ 2+

15. FAMILY HISTORY

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

(Check all that apply.)

□ Dementia or Alzheimer's disease

□ Heart disease

□ Stroke

□ Diabetes

□ Depression

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

□ Other (specify): _____

16. PLANNING FOR FUTURE HEALTH CARE

Do you have a medical Durable Power of Attorney for health care?

□ Yes □ No

If yes, please bring a copy.

Who should speak for you if you are unable to make health decisions?

Name: _____ Relationship: _____

Phone number: (_____) _____

Do you have a living will/advanced directive/out of hospital DNR form/POLST (Physicians Orders for Life Sustaining Treatment)? □ Yes □ No

If yes, please bring a copy.

17. GENERAL OUTLOOK

Task	No Help Needed	Help Needed	Who Helps?
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing or showering			
Walking across the room (includes using cane or walker)			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money (like keeping track of expenses or paying bills)			
Moderately strenuous housework such as doing the laundry			
Shopping for personal items like toiletries or medicines			
Shopping for groceries			
Driving			
Climbing a flight of stairs			
Getting to places beyond walking distance (e.g. by bus, taxi, or car)			

Compared to other people your age, how would you describe your health?

□ Excellent □ Good □ Fair □ Poor

Over the past two weeks, how often have you been bothered by any of the following problems:

Little interest or pleasure in doing things	Feeling down, depressed or hopeless
□ Not at all □ Several days □ More than half the days □ Nearly every day	□ Not at all □ Several days □ More than half the days □ Nearly every day

Do you use a walking aid such as a cane or a walker?

□ Yes □ No

If yes, which ones? □ Cane □ Walker □ Wheelchair

Are you afraid of falling?

□ Yes □ No

Have you had a fall in the past year?

□ Yes □ No

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

18. HEALTH MAINTENANCE

Do you always wear a seatbelt when you ride in a car? □ Yes □ No

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

□ Yes □ No

If yes, which ones:

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

Days per week	Amount of time per day (in minutes or hours)
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7	

Dates of your last vaccinations:

Influenza	Year:	Reaction: Yes / No
Pneumovax	Year:	Reaction: Yes / No
Tetanus booster	Year:	Reaction: Yes / No
Zoster (Shingles)	Year:	Reaction: Yes / No

Screening tests:

Test	Date most recently done	Results (if relevant)
Eye examination		
Hearing test		
Cards to check for blood in your stool		
Sigmoidoscopy		
Colonoscopy		

For men only:

Test	Date most recently done	Results (if relevant)
Prostate examination (rectal examination)		
PSA blood test (prostate cancer screening)		
If you ever smoked: abdominal ultrasound to check for abdominal aorta aneurysm.		
If age 80 or older: bone density test (DXA scan) to check for osteoporosis.		

For women only:

Test	Date most recently done	Results (if relevant)
Mammogram		
Pap smear		
Bone density test (DXA scan) to check for osteoporosis		

19. During the LAST 3 MONTHS, have you had any of the following symptoms or problems? (Please check all that apply.)

General Problems
- □ Weight loss
- □ Weight gain
- □ Fevers
- □ Chills
- □ Sweats
- □ Change of appetite

Ear, Nose, Mouth, Throat
- □ Trouble hearing
- □ Sore throat
- □ Allergies
- □ Sinus problems
- □ Teeth problems
- □ Hoarseness

Lung Problems
- □ Persistent cough
- □ Coughing up blood
- □ Wheezing
- □ Difficulty breathing or shortness of breath

Heart Problems
- □ Chest pain or tightness
- □ Swelling of feet
- □ Irregular heart beat
- □ Rapid heart beat

Eyes
- □ Trouble seeing
- □ Eye pain
- □ Dry eyes

Digestive 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

Gynecology Problems

□ Vaginal bleeding
□ Breast lumps or discomfort
□ Vaginal discharge

Kidney & Urinary Tract Problems

□ Frequent urination
□ Painful urination
□ Difficulty starting or stopping urination
□ Frequent urine infection
□ Urination at night
If yes, how many times a night:_____

□ Loss of urine or getting wet.
If yes:
- □ Sudden urge to void
- □ Loss with cough or laughing
- □ Continuous leakage
- □ Hard to start urination
- □ Cannot empty bladder
- □ Problem getting to toilet

Bone and Joint Problems

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

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

Mood/Sadness Problems

□ Depression □ Anxiety

Skin Problems

□ Rash □ Sores
□ Itching □ Easy bruising

Miscellaneous

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

20. <u>Please list specific health concerns that you would like your doctor to know about before your visit.</u>

Please be sure to include any information not already reported in this form.

1)

2)

3)

4)

5)

How did you hear about UCLA Geriatrics?

We are interested in learning how people hear about the geriatrics department at UCLA.

How were you referred to our services? (Please check all that apply.)
_____ Friend
_____ Family member
_____ Physician
_____ Health Talk
_____ Website
_____ Community agency
_____ Physician Referral Service
_____ Health Fair
_____ Other, please specify _____

What is your zip code? _____

What is your age? _____

Are you a member of the UCLA Healthcare 50 Plus? _____

If not, tear off the application below and mail it to us at:
UCLA Healthcare 50 Plus
1250 16th Street
Santa Monica, CA 90404

OR call 800-516-5323 for a membership application.

Name _____

Address _____

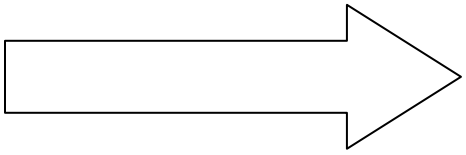
City, Zip Code _____

Phone (____)_____

Date of Birth _____

Thank you for taking the time to fill out the above questionnaire. Your time and effort is greatly appreciated.

Please continue to the next page.



Affix UCLA Label Here

May we contact you about research projects conducted by UCLA faculty?

□ Yes □ No

Preferred Title:

□ Mr.
□ Ms.
□ Mrs.
□ Other:

Print Name:_____

Address:

_____

_____

_____

_____

Phone: _____

Signature_____ Date _____

Form must be signed by the patient. No proxy signatures please.

THANK YOU FOR COMPLETING THIS FORM.