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MRN:
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(Patient Label)

PRE – VISIT QUESTIONNAIRE
DIVISION OF GERIATRIC MEDICINE

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 are much appreciated.

1. Date form completed: _______/ ________/ __________
   month day year

2. Home Address:
   Street ______________________________
   City, State, Zip ______________________________

3. Phone (_______) ___________________

4. Sex: ☐ Male ☐ Female

5. Primary spoken language: __________________________

   Secondary spoken language: __________________________

6. Who filled out this form? ☐ Self ☐ Other (Please give name below.)

   Name: __________________________________ Phone: (_______) ___________________

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

   ☐ Spouse ☐ Child ☐ Friend ☐ Other (specify) __________________________

7. Who has been your primary care doctor?

   Name **:** ______________________________

   Address: ______________________________
   City, State, Zip ______________________________

   Phone number: **(**______**)** __________________ Fax Number: **(**______**)** __________________

8. Do you plan to continue seeing the above listed primary care doctor? ☐ Yes ☐ No

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Please list names of other doctors/providers (e.g. cardiologist, neurologist, rheumatologist, orthopedist)

Provider's Name	Specialty	Address	Phone	Fax

Please list specific health concerns that you would like your doctor to know about before your visit.

1) ______________________________

____

____

2) ______________________________

____

____

3) ______________________________

____

____

4) ______________________________

____

____

5) ______________________________

____

____

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PRE – VISIT QUESTIONNAIRE
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PAST MEDICAL HISTORY

9. 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
- ☐ Diabetic vision loss
- ☐ Hearing loss/hearing aid
- ☐ Other (specify): ____________________

Heart
- ☐ Coronary artery disease
- ☐ Heart attack, year ____________
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Aortic stenosis or other heart valve problem
- ☐ Angina
- ☐ High cholesterol
- ☐ Pacemaker
- ☐ Atrial fibrillation or other heart rhythm problem
- ☐ Other (specify) ____________________

Glands
- ☐ Thyroid overactive (high)
- ☐ Thyroid underactive (low)
- ☐ Diabetes
- ☐ Hyperparathyroidism
- ☐ Other (specify): ____________________

Bones & Joints
- ☐ Gout
- ☐ Lower back pain
- ☐ Spinal Stenosis
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Sciatica
- ☐ Arthritis (indicate location):
  - ☐ Hip
  - ☐ Knee
  - ☐ Shoulder
  - ☐ Back
  - ☐ Hands
- ☐ Fractured bone (fill in table, below):
- ☐ Other (specify) ____________________

Lungs
- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Sleep apnea
- ☐ Chronic cough
- ☐ Need to use oxygen regularly
- ☐ Recurrent pneumonias
- ☐ Other (specify): ____________________

Kidney & Urinary Tract
- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Dialysis
- ☐ Enlarged prostate
- ☐ Urinary incontinence
- ☐ Kidney stones
- ☐ Prolapse of bladder/uterus
- ☐ Other (specify): ____________________

Skin
- ☐ Rosacea
- ☐ Seborrhea
- ☐ Eczema
- ☐ Yeast/fungus infections
- ☐ Other (specify): ____________________

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Fractured bone	Year Fractured	Brief explanation of how fracture happened (e.g., motor vehicle accident; athletic injury, fall while walking, etc.)
Example: Hip	2010	Tripped on curb

Gastrointestinal Tract

- ☐ Heartburn/reflux/GERD
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Liver disease/cirrhosis/hepatitis
- ☐ Gallbladder disease
- ☐ Colon polyps
- ☐ Diverticulosis
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Other (specify): ____________________

Other Health Problems

- ☐ Thrombosis/blood clots (specify if leg and/or lung) ______________________________
- ☐ Syncope (loss of consciousness)
- ☐ Hernia
- ☐ Anemia
- ☐ Sexual function problems (specify) ________________________
- ☐ Bleeding problems
- ☐ Chronic pain
- ☐ HIV/AIDS
- ☐ Other (specify): ____________________

Nervous System

- ☐ Dementia or Alzheimer's disease
- ☐ Parkinson's disease
- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Neuropathy/nerve damage
- ☐ Depression
- ☐ Anxiety
- ☐ Tremor
- ☐ Headache
- ☐ Insomnia
- ☐ Alcohol or drug problem
- ☐ Other (specify): ____________________

Cancer

- ☐ Lung
- ☐ Colon
- ☐ Breast
- ☐ Prostate
- ☐ Skin
- ☐ Other (specify): ____________________

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MRN:
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List Surgeries (Operations): **Date**

- ☐ Heart bypass ______
- ☐ Heart stent placement ______
- ☐ Heart valve replacement ______
  - ☐ Aortic ______
  - ☐ Mitral ______
  - ☐ Other: ______ ______
- ☐ Pacemaker placement ______
- ☐ Defibrillator/ICD placement ______
- ☐ Tonsils removed ______
- ☐ Appendix removed ______
- ☐ Gallbladder removed ______
- ☐ Knee replacement ______
- ☐ Hysterectomy ______

  Were ovaries removed? ☐ Yes ☐ No

Date:

- ☐ Hip repair due to hip fracture ______
- ☐ Hip replacement not due to hip fracture ______
- ☐ Cataract ______
- ☐ Skin cancer surgery ______
- ☐ Bladder surgery ______
- ☐ Hernia surgery ______
- ☐ Other Surgeries: (Please list below.) **Date:**

______
______
______
______
______
______

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MRN:
Patient Name:

(Patient Label)

10. List hospitalizations for the last 5 years.

Reason for hospitalization	Year

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

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

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12. List all medicines that you use (Include all Prescriptions, Non – Prescriptions, and Natural Products)

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

13. **Social History** (Check all that apply.)

With whom do you live?

- ☐ Alone
- ☐ Spouse or Partner
- ☐ Child
- ☐ Other, (specify):

____

Which of the following best describes your residence?

- ☐ Single – family house
- ☐ Condo/apartment
- ☐ Board & care/Assisted living
- ☐ Nursing home
- ☐ Continuing care retirement community
- ☐ Other (specify) ______________________

You are presently (check one):

- ☐ Single/Never married
- ☐ Married
- ☐ Divorced/Separated
- ☐ Widowed
- ☐ Living with significant other

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

Name of Facility: ____________________________

Name **:**______________________________________

Phone Number: **(**_______**)** ____________________

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PRE – VISIT QUESTIONNAIRE
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Do you consider yourself to be:	How much school did you complete?
☐ Heterosexual or straight ☐ Gay or lesbian ☐ Bisexual ☐ Prefer not to answer	☐ Less than 8th grade ☐ Some high school ☐ High school graduate ☐ Some college ☐ College graduate ☐ Graduate school
How many children do you have? ___________ Are you in regular contact with your children? ☐ Yes ☐ No Do you have a religious affiliation? ☐ Yes ☐ No *If yes,* please state: _________________________ *If yes,* do you actively practice? ☐ Yes ☐ No	You are presently (check one) ☐ Retired/Not working ☐ Working part – time ☐ Working Full – Time

List your principal occupation and any other significant past occupations.

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________

Please list name(s) and phone number(s) of those persons you would call if you were sick and needed help:

Name **:** ______________________ Phone Number: **(**_______**)** __________________

Relationship **:** _____________________

Name **:** ______________________ Phone Number: **(**_______**)** __________________

Relationship **:** _____________________

Name **:** ______________________ Phone Number: **(**_______**)** __________________

Relationship **:** _____________________

Do we have your permission to speak to the person(s) listed above on your behalf? ☐ Yes ☐ No

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

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

☐ Yes ☐ No

If yes, please list name(s) and contact information__________________________

____

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

16. 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 members(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

17. Do you provide care for a family member? ☐ Yes ☐ No

18. Do you currently use a home health care agency? ☐ Yes ☐ No

If yes, please list name(s) and contact information ___________________________________

____

19. On any day in the past year, have you ever had:

- More than 3 drinks containing alcohol? ☐ Yes ☐ No

Think about your typical week:

- On average, how many days a week do you drink alcohol? ___________
- On a typical drinking day, how many drinks do you have? ___________

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20. Has anyone ever been concerned about your drinking? ☐ Yes ☐ No

21. Have you ever used tobacco products including cigarettes? ☐ Yes ☐ No, skip to 21

If yes – Do you currently use tobacco products?

☐ Yes – If *yes*, what kind of tobacco products? ______________________

If cigarettes, 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+

22. Do you use marijuana? ☐ Yes ☐ No ☐ Prefer not to answer

If yes, for what purpose? ☐ Medical ☐ Recreational

23. Family History

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

(Check all that apply)	**Family Member**
☐ Dementia or Alzheimer's disease	
☐ Heart disease	
☐ Stroke	
☐ Diabetes	
☐ Depression	
☐ Cancer:	
☐ Breast	
☐ Prostate	
☐ Colon/Rectum	
☐ Lung	
☐ Skin	
☐ Lymphatic	
☐ Other (specify): ________________________	

Did either of your parents have a hip fracture? ☐ Yes ☐ No ☐ Don't know

24. Advance Care Planning

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

☐ Yes (*if yes*, please provide a copy) ☐ No

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

Name **:** ________________________________ Relationship: ______________________________

Phone Number: **(**______**)** ________________

Do you have any other advanced directive such as a living will, out of the hospital DNR form/POLST (Physicians Orders for Life Sustaining Treatment)?

☐ Yes (*if yes*, please provide a copy.) ☐ No

25. **General Function:**

Please indicate if you need help doing the following tasks and who helps you.

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 such as toiletries or medicines			
Shopping for groceries			
Driving			
Climbing a flight of stairs			
Getting to places beyond walking distance (bus, taxi, or car)			

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

☐ Yes ☐ No

If yes, which ones? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Motorized scooter

27. **Falls**

Are you afraid of falling**?** ☐ Yes ☐ No

Have you had a fall in the past year? ☐ Yes ☐ No

If yes, how many times have you fallen during the past year _______

When was your most recent fall? _______________

Below, please indicate the circumstances and consequences of your most recent fall.

Where were you when you fell? ____

What were you doing when you fell? ____

Did you trip over something	☐ Yes	☐ No
Did you have lightheadedness or palpitations prior?	☐ Yes	☐ No
Did you lose consciousness?	☐ Yes	☐ No
Did you lose control of your urine when you fell?	☐ Yes	☐ No
Were you able to get up by yourself?	☐ Yes	☐ No
Were you injured?	☐ Yes	☐ No
Did you need to see a doctor?	☐ Yes	☐ No

If yes, what was the injury? ________________________________

28. **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:

☐ Resistance or strength training (e.g., using weights or rubber bands)

☐ Bicycling or stationary bike

☐ Aerobics or exercise classes

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

☐ Dancing ☐ Swimming ☐ Pilates ☐ Other (specify)

☐ Walking ☐ Tennis ☐ Golf ______________________

☐ Jogging ☐ Bowling ☐ Yoga

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Dates of your most recent vaccinations:

Influenza	Year:	Reaction: ☐ Yes ☐ No
Pneumovax	Year:	Reaction: ☐ Yes ☐ No
Tetanus ☐ Td ☐ Tdap ☐ Don't know	Year:	Reaction: ☐ Yes ☐ No
Zoster (Shingles)	Year:	Reaction: ☐ Yes ☐ No
Prevnar	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		
Colonoscopy		

For MEN only:

Test	Date most recently done	Results (if relevant)
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		

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29. **<u>During the LAST MONTH, have you had any of the following symptoms or problems?</u>**
(Please check all that apply.)

General Problems

- ☐ Weight loss
- ☐ Weight gain
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Change of appetite
- ☐ Other: _______________

Ear, Nose, Mouth, Throat

- ☐ Trouble hearing
- ☐ Sore throat
- ☐ Allergies
- ☐ Sinus problems
- ☐ Teeth problems
- ☐ Hoarseness
- ☐ Snoring
- ☐ Other: _______________

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 movements
- ☐ Other: _______________

Gynecology Problems

- ☐ Vaginal bleeding
- ☐ Breast lumps or discomfort
- ☐ Vaginal discharge
- ☐ Other: _______________

Lung Problems

- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Difficulty breathing or shortness of breath
- ☐ Other: _______________

Heart Problems

- ☐ Chest pain or tightness
- ☐ Swelling of feet
- ☐ Irregular heart beat
- ☐ Rapid heart beat
- ☐ Other: _______________

Eyes

- ☐ Trouble seeing
- ☐ Eye pain
- ☐ Dry eyes
- ☐ Other: _______________

Bone and Joint Problems

- ☐ Leg pain on walking
- ☐ Back or neck pain
- ☐ Joint pain or stiffness
- ☐ Foot problems
- ☐ Falls
- ☐ Other: _______________

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
- ☐ Agitation
- ☐ Problems with memory or difficulty thinking
- ☐ Other: _______________

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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

Mood/Sadness Problems

☐ Depression
☐ Anxiety
☐ Other: _______________

Skin Problems

☐ Rash
☐ Itching
☐ Sores
☐ Easy bruising
☐ Other: _______________

Miscellaneous

☐ Excessive thirst
☐ Feel too hot or too cold
☐ Problems with sexual function
☐ Bleeding problems
☐ Other: _______________

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	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

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MRN:
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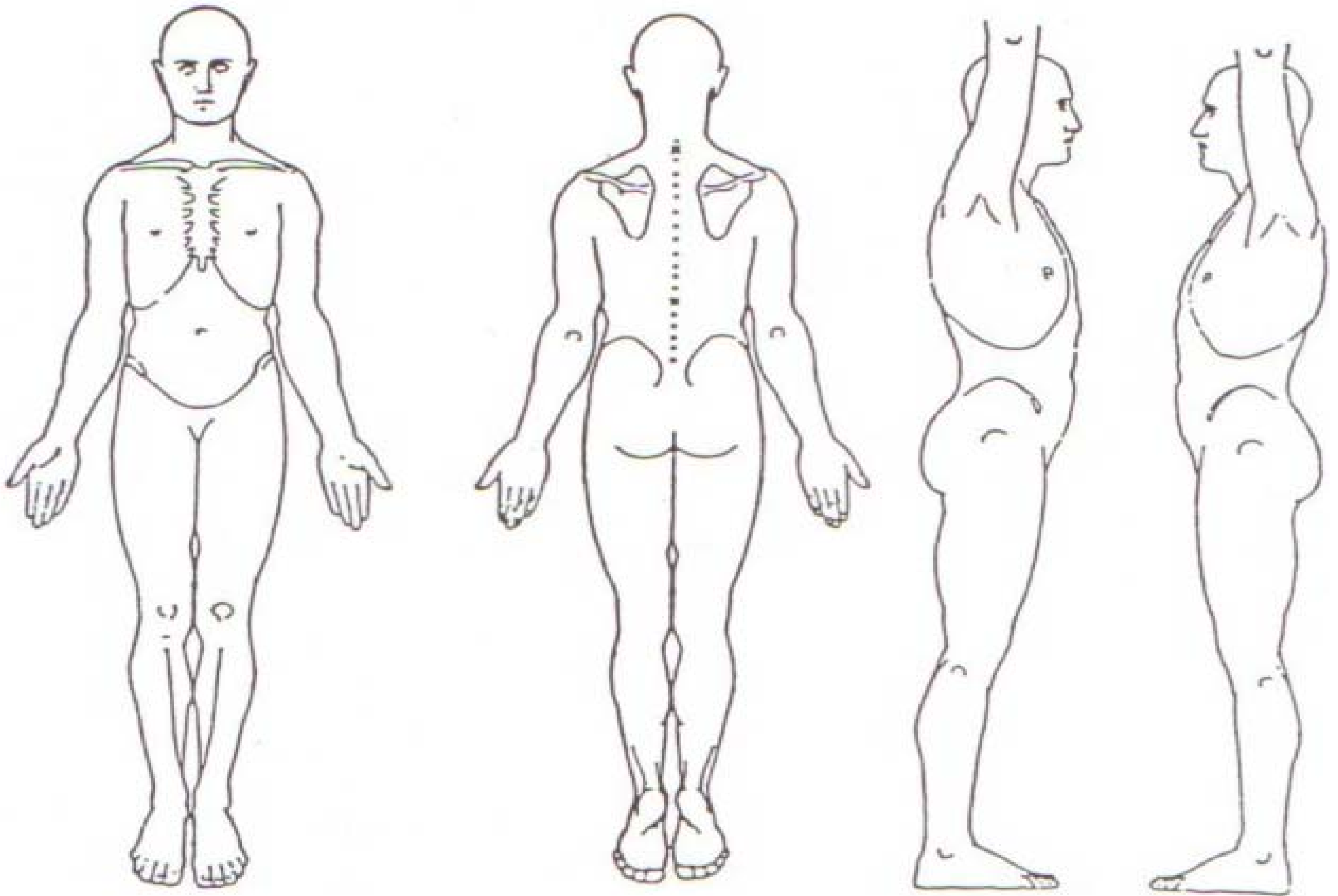
30. Pain

On the diagram below, shade the areas where you currently feel pain. Put an x on the area that hurts the most.



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Anything else we should know about you?

____

____

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 ___________________________

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 ___________________

UCLA Health

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

May we contact you about research projects conducted by UCLA faculty? ☐ Yes ☐ No

Preferred Title:
- ☐ Mr.
- ☐ Ms.
- ☐ Mrs.
- ☐ Other: ______________________________

Print Name ____________________________________

Address:
____
____
____
____

Phone: ______________________________

Patient or Representative Signature __________________________ Date _______ Time ______

If signed by someone other than the patient, please specify relationship to the patient: ___________

Interpreter Signature _________________________ ID # _______ Date ________ Time _______