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
- □ Opioid
- □ Cannabis
- □ Sedative, Hypnotic or Anxiolytic

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
- □ Alcohol Abuse
- □ Alcohol Dependency (Current)
- □ Alcohol Dependency (In Remission)

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

<table>
<thead>
<tr>
<th>□ Yes</th>
<th>□ No</th>
<th>Do you have increasing or worsening weakness or tiredness that is new to you within the last year?</th>
</tr>
</thead>
</table>

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** __________________________

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<tr>
<th>□ 0</th>
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</table>

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.

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<tr>
<th>□ 0</th>
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</table>

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**.

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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**.

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<th>□ 0</th>
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</tr>
</thead>
</table>

No Pain  
**Pain As Bad As You Can Imagine**

## Vision

<table>
<thead>
<tr>
<th>□ Yes</th>
<th>□ No</th>
<th>Have you had any recent changes in your vision?</th>
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</table>

## Respiratory/Pulmonary (Lungs)

<table>
<thead>
<tr>
<th>□ Yes</th>
<th>□ No</th>
<th>Have you recently had trouble breathing?</th>
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<table>
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<tr>
<th>□ Yes</th>
<th>□ No</th>
<th>Do you have a persistent cough that will not go away?</th>
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</thead>
</table>
### 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 severe 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:**