LFMG PRE-VISIT QUESTIONNAIRE

Name: _____Date of Birth:_____

TODAY'S VISIT

What are you hoping to accomplish with this visit?_____

_____

Is there anything else you'd like to work on to improve your health?

_____

If you have one of the following conditions, please answer:

Diabetes: Any problems with medications?
Yes No

Home glucose readings

_____

High blood pressure: Any problems with meds?
Yes No

Home BP readings

_____

High cholesterol: Any problems with meds?
Yes No

Depression: Any problems with meds?
Yes No

Any thoughts of hurting yourself? Yes No

BETWEEN VISITS

Have you been to the **ER, hospital, or another doctor** since last seen here? Yes No
Please explain:

_____

_____

Medications: Do you have any trouble taking any of your medications? Yes No
If so, what sort of trouble?_____

Have you developed any new drug **allergies**?

_____

LIFESTYLE

Exercise: What do you do?

_____

How long? _____

How often? _____

Can you walk a block or climb a flight of stairs without getting short of breath? Yes No

Tobacco: How much do you use?

_____

Are you interesting in quitting? Yes No

Alcohol: How many drinking days do you have per week? _____

On average how many drinks per drinking day?

_____

Have you had more than 4 drinks in a day in the past 3 months? Yes No

Are you or others concerned about your drinking? Yes No

Caffeine: How much caffeine do you consume per day? (e.g., coffee, tea, chocolate, soda_____

Falls: Have you fallen in the past year?
Yes No
Do you have problems with walking or balance?
Yes No

Depression screen: Over the last 2 weeks have you been bothered by little interest or pleasure in doing things? Yes No
Or are you feeling down, hopeless, or depressed? Yes No

Safety: Are you in a relationship where you feel unsafe or have been hurt? Yes No

Do you regularly wear a seatbelt? Yes No

HIV testing: Would you like HIV testing?
Yes No

(If yes, please tell the nurse.) *HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of injection drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.*

Birth control method (if applicable):

_____

End-of-life care: Do you want to discuss end-of-life issues? Yes No

UPDATE
Has anything new come up in your **family history**? (new illness among blood relatives)

_____

Are you experiencing any of the following?
*Please circle any issues above which are **new** or that you specifically want to address.*

Constitutional symptoms:
fever weight loss extreme fatigue

Eyes: double vision sudden loss of vision

Ears, nose, mouth, and throat:
sore throat runny nose ear pain

Heart: chest pain palpitations

Respiratory: cough wheezing shortness of breath

Gastrointestinal: nausea vomiting abdominal pain constipation diarrhea blood in stools

Genitourinary:
irregular menses bloody urine
vaginal bleeding after menopause
frequent or painful urination impotence

Do you lose control of your urine to the point you would like to know how to treat it?
Yes No

Skin: rash changing mole

Sleep: snoring difficulty sleeping Do you stop breathing during sleep or have concerns about sleep apnea? Yes No

Neurological: headache persistent weakness or numbness on one side of the body falling

Musculoskeletal: joint pain muscle weakness

Mental Health: depression anxiety suicidal thoughts

Endocrine: excessive thirst breast lump cold or heat intolerance

Hematologic: unusual bruising or bleeding enlarged lymph nodes

Allergic: hay fever

If you need help between appointments, please call our office at (402) 488-7400

Our goal is to see you the day you call in or the next day unless this is annual wellness visit. It is helpful if you call first thing in the morning.

One of our medical staff will help you decide if you need to be seen and if any tests are needed prior to your appointment