Complete Rural
Medicine

PRE-VISIT QUESTIONNAIRE

Date of Service:_________________________

Name: ____**DOB**______________________ **MR#**__________________

TODAY'S VISIT

What are you hoping to accomplish today? ____

____

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

____

<u>If you have one of the following conditions, please answer:</u>

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 suicidal thoughts? □ Yes □ No

<u>BETWEEN VISITS</u>

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

Please explain: ____

<u>LIFESTYLE</u>

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

Smoking: How much do you smoke? ________________________________ Are you interested 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

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

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

Do you regularly wear your 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.*

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

Birth Control Method (if applicable): ____

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

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

Medications: Do you have any trouble taking any of your medications? □ Yes □ No

If so, what sort of trouble ____

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

End-of-Life Care: Do you want to discuss end-of-life issues? □ Yes □ No