# Georgina NPLC Pre-Visit Questionnaire

Thank you for completing this form before your visit. It will allow your NP to perform the most complete intake history 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:** (___ ) __________________ **Alternate:** (____)_____________________

**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 provider?**

Name: ____________________________

Address: ___________________________

Phone number: (___ )________________

Fax Number: (___ ) _________________

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

☐ Yes ☐ No ☐ Not sure

# PAST MEDICAL HISTORY

**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
- ☐ Celiac
- ☐ Other (specify)___________

## BONES & JOINTS

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

**GLANDS**

- ☐ Thyroid overactive (high)
- ☐ Thyroid underactive (low)
- ☐ Diabetes
- ☐ Thyroid
- ☐ Other (specify):________

**KIDNEY & URINARY TRACT**

- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Enlarged Prostate
- ☐ Urinary incontinence
- ☐ Kidney stones
- ☐ Other (specify): _________

**LUNGS**

- ☐ Asthma
- ☐ Bronchitis
- ☐ Recurrent pneumonias
- ☐ COPD/emphysema
- ☐ Other (specify): ___________

**NERVOUS SYSTEM**

- ☐ Dementia or Alzheimer's disease
- ☐ Parkinson's disease
- ☐ Epilepsy or seizures
- ☐ Neuropathy/nerve damage
- ☐ Depression
- ☐ Anxiety
- ☐ Stroke
- ☒ Other (specify): ___________

**CANCERS**

☐ Breast ☐ Prostate ☐ Colon/Rectum ☐ Lung ☐ Skin ☐ Lymphatic

☐ Other (specify): __________________________________________________

**OTHER HEALTH PROBLEMS**

- ☐ Thrombosis/blood clots:
  - ☐ In the leg ☐ In the lung
- ☐ Hernia
- ☐ Anemia
- ☐ Syncope (loss of consciousness)
- ☐ Sexual function problems (specify): ________________________________
- ☐ 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: ____________________
- ☐ Wisdom teeth
- ☐ Other Surgeries/hospitalizations: (Please list below)

______________________________________________ Date: ____________________

______________________________________________ Date: ____________________

______________________________________________ Date: ____________________

______________________________________________ Date: ____________________

**List all medications that you use: (include all prescriptions, over the counter products, and supplements). If more than 5 please attach pharmacy list.**

| Current Medication<br>ie: Tylenol | What Strength?<br>ie: 500mg | How many? How often? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Do you have any drug allergies?** ☐ Yes ☐ No

**If yes,** please list name of drug and specific reaction:

| | Indicate Reaction | | | |
|---|---|---|---|---|
| **Name of Drug** | **Rash** | **Shortness of Breath** | **Nausea** | **Other (Specify)** |
| | | | | |
| | | | | |
| | | | | |

**Dates of your last vaccinations. (If you have record please bring with you)**

| Flu vaccine | Year: | Reaction: Yes / No |
|---|---|---|
| Pneumonia vaccine | Year: | Reaction: Yes / No |
| Tetanus booster | Year: | Reaction: Yes / No |
| Zostavax (Shingles) | Year: | Reaction: Yes / No |

## Screening Tests

### MALE & FEMALE

| TEST | DATE MOST RECENTLY DONE | RESULTS (IF RELEVANT) |
|---|---|---|
| Eye examination | | |
| Hearing Test | | |
| Bone Mineral Density (BMD) for osteoporosis | | |
| Colonoscopy | | |
| Cards to check for blood in your stool | | |
| Fasting Bloodwork | | |

### MEN

| TEST | DATE MOST RECENTLY DONE | RESULTS (IF RELEVANT) |
|---|---|---|
| Prostate Exam (rectal exam) | | |
| PSA blood test (prostate cancer screening) | | |
| If you have ever smoked then an abdominal ultrasound to check for aortic aneurysm | | |

### WOMEN

| TEST | DATE MOST RECENTLY DONE | RESULTS (IF RELEVANT) |
|---|---|---|
| PAP test (cervical cancer) | | |
| Mammogram | | |

## 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 the 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/university
   - ☐ College/University 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. ________________________________

**Do you drink alcohol, including beer and wine, or other alcohol (i.e. vodka, whiskey, gin)?**

☐ Daily

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

☐ Less than once a week

☐ Never

**How much do you drink at a time? (One drink = 12oz of beer or 8-9oz of malt liquor or 5oz of table wine or 1.5oz of hard liquor)**

☐ 1 drink ☐ 4 drinks

☐ 2 drinks ☐ 5 or more drinks (number:_____)

☐ 3 drinks

**Have you EVER smoked cigarettes?**

☐ Yes ☐ No

**If yes:**

**Do you currently smoke cigarettes?**

☐ Yes……….If yes, how many packs per day? ☐ **¼** ☐ **½** ☐ **1** ☐ **1 ½** ☐ **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** ☐ **1 ½** ☐ **2+**

☐ Would you like to quit? ☐ Yes ☐ No

**Do you use street drugs? (i.e. marijuana, cocaine etc.)**

☐ Yes ☐ No

List: ________________________________________ ____________________________________

________________________________________ ____________________________________

## Family History:

**Have any members of your family had any of the following conditions? (Check all that apply)**

☐ Dementia or Alzheimer's disease ☐ Depression

☐ Heart disease ☐ Diabetes

☐ Stroke ☐ Cancer: ☐ **Breast** ☐ **Prostate** ☐ **Colon/Rectum**

☐ Other ☐ **Lung** ☐ **Skin** ☐ **Lymphatic**

## 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

**LUNG PROBLEMS:**

☐ Persistent Cough

☐ Coughing up blood

☐ Wheezing

☐ Difficulty breathing or shortness of breath

**EAR, NOSE, MOUTH, THROAT:**

☐ Trouble hearing ☐ Sinus Problems

☐ Sore Throat ☐ Teeth Problems

☐ Allergies ☐ Hoarseness

**HEART PROBLEMS:**

☐ Chest Pain or tightness

☐ Swelling of feet

☐ Irregular heart beat

☐ Rapid heart beat

**EYES:**

☐ Trouble seeing ☐ Dry eyes

☐ Eye pain

**MISCELLANEOUS:**

☐ Bleeding problems ☐ Feel too hot or too cold

☐ Excessive thirst ☐ Problems with sexual function

**DIGESTIVE PROBLEMS:**

- ☐ Difficulty swallowing
- ☐ Abdominal Pain
- ☐ Change in bowel habits
- ☐ Frequent indigestion or heartburn
- ☐ Frequent nausea or vomiting
- ☐ Persistent constipation
- ☐ Bleeding from rectum
- ☐ Black bowel movement

**GYNECOLOGICAL PROBLEMS:**

- ☐ Vaginal bleeding
- ☐ Breast lumps or discomfort
- ☐ Vaginal discharge

**SKIN PROBLEMS:**

- ☐ Rash
- ☐ Itching
- ☐ Sores
- ☐ Easy Bruising

**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
- ☐ Problems with sleep
- ☐ Frequent dizzy spells
- ☐ Hallucinations
- ☐ Passing out or fainting
- ☐ Tremor or shaking
- ☐ Paralysis, leg or arm weakness
- ☐ Numbness or loss of feeling
- ☐ Serious problem with memory or difficulty thinking

**KIDNEY AND URINARY TRACT PROBLEMS:**

- ☐ Frequent urination
- ☐ Difficulty starting or stopping urination
- ☐ Painful 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

## PLEASE LIST SPECIFIC HEALTH CONCERNS THAT YOU WOULD LIKE YOUR NURSE PRACTITIONER TO KNOW ABOUT BEFORE YOUR VISIT:

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

1.

2.

3.

4.

5.