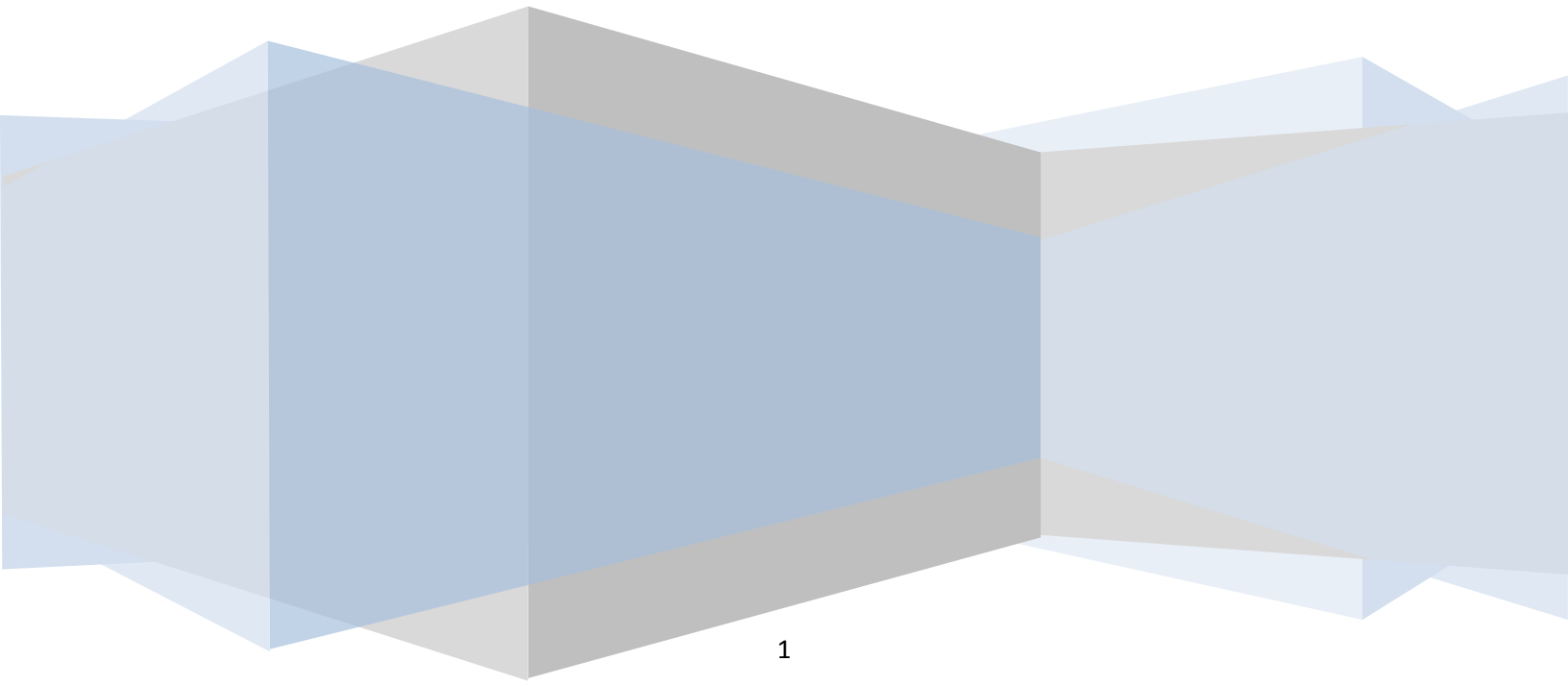
Pre-Visit Assessment

Version 2.1

"Ask not what your doctor can do for you,
ask what you can do for your doctor and yourself"

with gratitude to President John F. Kennedy



CONTENTS

Basic Information

Patient name

Person answering questions

Date Pre-Visit Assessment completed

Date of Birth

Sex ○ Male ○ Female

Main Occupation/Role During Your Life

Place/Country of Birth

Marital Status

○ Single ○ Divorced ○ Married
○ Partnered ○ Separated ○ Widowed

Living Situation

○ Alone ○ With spouse or partner
○ With child ○ With other relative
○ With friend
○ Other (specify):

Household Type

○ Apartment ○ Assisted-living facility
○ Nursing home ○ Own a home
○ Senior apartment
○ Other (specify):

Highest Level of Education Completed

○ Some grade school ○ High school
○ Some college ○ College
○ Some grad school ○ Grad school
○ Other ○ Prefer not to answer

Race / ethnicity

○ American Indian / Alaska Native
○ Asian ○ Black / African-American
○ Hispanic / Latino ○ Two or more races
○ White / Caucasian ○ Unknown
○ Other ○ Prefer not to answer

Religion/Spirituality

○ Agnostic ○ Atheist ○ Baha'i
○ Buddhist ○ Catholic ○ Hindu
○ Jewish ○ Muslim
○ Native American
○ Protestant ○ Secular Humanist
○ Shinto ○ Sikh
○ Spiritual but not religious ○ Taoist
○ Unitarian Universalist ○ Unknown
○ Other ○ Prefer not to answer

Sexual orientation

○ Heterosexual ○ Homosexual
○ Other ○ Prefer not to answer

Activities

Which of the following do you do at least weekly (choose all that apply):

- ☐ Attend religious services
- ☐ Cook
- ☐ Do a crossword puzzle
- ☐ Drive
- ☐ Exercise
- ☐ Go dancing
- ☐ Go out with others
- ☐ Go to the casino
- ☐ Go to the gym
- ☐ Go to the movies
- ☐ Listen to music
- ☐ Listen to the radio
- ☐ Play a sport
- ☐ Play bingo
- ☐ Pursue a hobby
- ☐ Read
- ☐ Rent a movie
- ☐ Ride a bicycle
- ☐ Take a walk
- ☐ Talk to people on the phone
- ☐ Use a computer for email
- ☐ Use a computer otherwise
- ☐ Visit with family
- ☐ Volunteer
- ☐ Watch TV
- ☐ Work at a paying job
- ☐ Write letters
- ☐ **None of the above.**

Comments:
Staying active is one of the most important things you can do to stay physically and mentally healthy.

Advance Directives

Which of the following advance directives do you have in place (choose all that apply):

- ☐ Do Not Resuscitate (DNR) from
- ☐ Durable power of attorney
- ☐ Health Care Proxy (HCP) form
- ☐ Medical Orders for Life-Sustaining Treatment (MOLST) form
- ☐ Living will
- ☐ Regular power of attorney
- ☐ Regular will
- ☐ **No advance directives at this time.**

Caregiving

If you help care for a loved one, which of the following have you experienced within the past month?

- ☐ Been edgy or irritable
- ☐ Been upset about the support your family provides
- ☐ Been upset that your loved one has changed so much from his/her former self
- ☐ Felt all alone
- ☐ Felt completely overwhelmed
- ☐ Felt ill (headaches, stomach problems, or common cold)
- ☐ Felt loss of privacy and/or personal time
- ☐ Felt strained between caring for your loved one and work and family responsibilities
- ☐ Felt that you couldn't leave your loved one alone
- ☐ Felt useful and needed
- ☐ Found your loved one's living situation inconvenient or a barrier to care
- ☐ Had a crying spell
- ☐ Had back pain
- ☐ Had difficulty making decisions
- ☐ Had sleep disturbed because of caring for your loved one
- ☐ Had trouble keeping your mind on what you were doing
- ☐ **None of the above.**

Comments:
The symptoms above are commonly experienced when caregiving. Caregiving can be very stressful.

A caregiver support group may help you deal with your stress and realize that you are not alone in your caregiving role. Asking for help from friends, relatives, or a home care agency might also help you to take care of yourself as well as your loved one.

Reference:
Adapted from the American Medical Association Caregiver Self-Assessment Questionnaire
http://www.ama-assn.org/ama/pub/category/5037.html

Daily Tasks

Check one answer in each row that best describes how difficult it is for you to do the following tasks:

	No difficulty	Can do it myself with special equipment	Need someone to help me
Bathe			
Dress			
Eat			
Get in and out of bed			
Get in and out of chair			
Use the bathroom			
Walk			

Check one answer in each row that best describes how you manage the following activities:

	Do it myself	Need some help	Someone else does it for me
Cook			
Do housework			
Do laundry			
Manage money			
Shop for groceries			
Take medication			
Use the telephone			

Comments:
Contact a relative, friend, neighbor or home care agency if you are having difficulty managing on your own.

References:
Adapted from Activities of Daily Living Scale, Katz,S, Down, TD, Cash, HR, et al (1970) Progress in the Development of the Index of ADL, Gerontologist 10:20-30 and Instrumental Activities of Daily Living Scale, Lawton (1969) Assessment of older people: self-maintaining and instrumental activities of daily living. Gerontologist 9:179-86

Feelings & Attitudes

Which of the following feelings or attitudes do you experience at least weekly?

- ☐ Anger
- ☐ Anxiety or nervousness
- ☐ Boredom
- ☐ Depression or sadness
- ☐ Embarrassment
- ☐ Fear or worry
- ☐ Frustration
- ☐ Guilt
- ☐ Happiness
- ☐ Helplessness
- ☐ Hopelessness
- ☐ Impatience or irritability
- ☐ Indecisiveness
- ☐ Indifference
- ☐ Jealousy
- ☐ Loneliness
- ☐ Negativity
- ☐ Suspiciousness or paranoia
- ☐ Thoughtfulness
- ☐ Thoughtlessness
- ☐ **None of the above.**

Comments:
Discuss your overall feelings and attitudes with your primary care doctor.

Try to prioritize the ones that make your life less enjoyable and find one approach that can make a difference (e.g. venting, lifestyle changes, education, relaxation therapy, exercise, meditation, talking to a counselor, medication adjustments, new medications).

Function

Which of the following apply to your loved one?

- ☐ Complains of forgetting location of objects or not being able to find the right word - 2
- ☐ Decreased job functioning evident to coworkers or difficulty in traveling to new locations - 3
- ☐ Decreased ability to perform complex tasks such as planning dinner for guests, handling finances, or going shopping - 4
- ☐ Requires assistance in choosing proper clothing for the season or occasion - 5
- ☐ Difficulty putting clothing on properly without assistance - 6a
- ☐ Unable to bathe properly, fear of bathing, or requires assistance adjusting bath water temperature - 6b
- ☐ Inability to handle the mechanics of going to the bathroom such as forgetting to flush or not wiping properly - 6c
- ☐ Urinary incontinence, occasional or more frequent - 6d
- ☐ Stool incontinence, occasional or more frequent - 6e
- ☐ Ability to speak limited to about half a dozen words in an average day - 7a
- ☐ Intelligible vocabulary limited to a single word in an average day - 7b
- ☐ Unable to walk without assistance - 7c
- ☐ Unable to sit up independently - 7d
- ☐ Unable to smile - 7e
- ☐ Unable to hold head up - 7f
- ☐ **No difficulties expressed or observed - 1**

Medical Problems

For which of the following medical problems have you been in the hospital, had surgery, or take a medication (choose all that apply)?

- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Cancer
- ☐ Cataracts
- ☐ Congestive heart failure
- ☐ COPD or emphysema
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD/reflux disease
- ☐ Glaucoma
- ☐ Hearing impairment
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism/low thyroid
- ☐ Kidney failure
- ☐ Macular degeneration
- ☐ MI/heart attack
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Vitamin B12 deficiency
- ☐ **None of the above.**
- ☐ Other (please specify):

Medications

Which of the following types of medications have you taken in the past week?

- ☐ Blood pressure medication
- ☐ Heart medication (e.g. for irregular rhythm, congestive heart failure, or angina)
- ☐ Medication for anxiety or nervousness
- ☐ Medication for depression
- ☐ Medication for high cholesterol
- ☐ Medication for Parkinson's Disease
- ☐ Medication for urine incontinence or leakage
- ☐ Narcotic pain medication (for example Darvocet, Duragesic patch, Lortab, Oxycontin, Roxicet)
- ☐ Over-the-counter allergy medication
- ☐ Over-the-counter cold remedy
- ☐ Over-the-counter sleeping pill (for example, Tylenol PM, Advil PM, other)
- ☐ Prescription sleeping pill
- ☐ Seizure medication
- ☐ "Water" pill
- ☐ **None of the above.**

Memory

Do you experience any of the following on a regular basis?

- ☐ Feel irritable, agitated, suspicious, or see, hear, or believe things that aren't real
- ☐ Feel sad, down in the dumps, or tearful
- ☐ Forget appointments, family occasions, or holidays
- ☐ Get lost when going for a walk or driving
- ☐ Have no interest in hobbies, reading, going to religious services, or other social activities
- ☐ Have trouble doing calculations, managing finances, or balancing the checkbook
- ☐ Have trouble finding the words you want to say, finishing sentences, or naming people or things
- ☐ More forgetful or can't remember things that happened recently
- ☐ Need help eating, dressing, bathing, or using the bathroom
- ☐ Need reminders to do things like chores, shopping, or taking medicine
- ☐ Repeat yourself or ask the same questions over and over
- ☐ **None of the above.**

Comments:
Any of the answers above may indicate that you have a problem with your memory.

Medication side effects, depression, thyroid disease, and other treatable problems can contribute to memory impairment.

Discuss your symptoms with your primary care doctor. Additional examination and testing, as well as consultation with a neurologist, neuropsychologist, psychiatrist or other specialist may be recommended to help determine what is causing your memory difficulty and what can be done about it.

References:
Alzheimer's Checklist
http://alz.org/alzheimers_disease_symptoms_of_alzheimers.asp

Adapted from Mundt JC, Freed DM, Griest JH. Lay person-based screening for early detection of Alzheimer's disease: development and validation of an instrument. J Gerontol Psychol Sci Sco. 2000, 55B: 163-170.

Mood

Which of the following apply to you?

- ☐ Feel afraid that something bad is going to happen to you
- ☐ Feel down in the dumps most of the time
- ☐ Feel pretty worthless the way you are now
- ☐ Feel that you have more problems with memory than most
- ☐ Feel that your life is empty
- ☐ Feel that your situation is hopeless
- ☐ Feel tired most of the time
- ☐ Feel unhappy most of the time
- ☐ Feel unsatisfied with your life
- ☐ Have dropped many of your activities and interests
- ☐ Often feel helpless
- ☐ Often get bored
- ☐ Prefer to stay at home rather than going out and doing new things
- ☐ Think that most people are better off than you are
- ☐ Think that there is nothing much to live for
- ☐ **None of the above.**

Comments:
Any of the above can be a symptom of depression. Depression is common and treatable. Specific medical illnesses and medication side effects can cause depression.

Talk to your primary care doctor if you experience 5 or more of the above or you just feel depressed.

References:
Geriatric Depression Rating Scale
http://www.stanford.edu/~yesavage/Testing.htm

Brink TL, Yesavage JA, Lum O, Heersema P, Adey MB, Rose TL: Screening tests for geriatric depression. Clinical Gerontologist 1: 37-44, 1982.

Nutrition

Which of the following apply to you?

- ☐ Don’t always have enough money to buy the food I need
- ☐ Eat alone most of the time
- ☐ Eat few fruits, vegetables, or milk products
- ☐ Eat fewer than two meals a day
- ☐ Have a condition that made me change the kind or amount of food I eat
- ☐ Have gained or lost at least 10 pounds in the past six months
- ☐ Have three or more drinks of beer, wine, or liquor almost every day
- ☐ Have tooth or mouth problems that make it hard for me to eat
- ☐ Not always physically able to shop, cook, or feed myself
- ☐ Take three or more different prescribed or over-the-counter drugs each day
- ☐ **None of the above.**

Comments:
Any of the above could indicate you are not eating properly.

Talk with your primary doctor as soon as possible about what may be causing your nutritional problems and what can be done about it.

References:
DETERMINE Checklist, Nutrition Screening Initiative, AAFP / ADA / NCOA, J Nutr Elder. 1995;14(4):15-29. Using the Nutrition Screening Initiative to survey the nutritional status of clients participating in a home delivered meals program.

Overall Health

How would you rate your OVERALL HEALTH?

- Poor
- Fair
- Good
- Excellent

How has your overall health CHANGED over the past year?

- A lot worse
- A little worse
- About the same
- A little better
- A lot better

Pain

How much pain do you usually have?

- **0 - No Pain**
- 1 - Mild Pain
- 2 - Annoying Pain
- 3 - Nagging Pain
- 4 - Uncomfortable Pain
- 5 - Troublesome Pain
- 6 - Distressing Pain
- 7 - Intense Pain
- 8 - Dreadful Pain
- 9 - Excruciating Pain
- 10 - Worst Possible Pain

How much pain do you have right now?

- **0 - No Pain**
- 1 - Mild Pain
- 2 - Annoying Pain
- 3 - Nagging Pain
- 4 - Uncomfortable Pain
- 5 - Troublesome Pain
- 6 - Distressing Pain
- 7 - Intense Pain
- 8 - Dreadful Pain
- 9 - Excruciating Pain
- 10 - Worst Possible Pain

Comments:
Discuss any pain with your primary care doctor or a pain specialist, especially if chronic and 4 out of 10 severity or more.

Reference:
Graphic from Challenges in Pain Management at the End of Life, American Family Physician, 10/1/2001:
http://www.aafp.org/afp/20011001/1227.html

Safety

Which of the following apply to your home situation?

- ☐ Appliances don’t have an auto-shut off feature
- ☐ Bathroom door has a lock or can’t be unlocked from the outside
- ☐ Cleaning supplies are not locked up
- ☐ Dangerous items or old medications have not been removed from the medicine cabinet
- ☐ Electric blanket, heater, or heating pad are present
- ☐ Electricity to garbage disposal is not turned off
- ☐ Fire extinguisher is not nearby
- ☐ Firearms are present
- ☐ Grab bars are not present in shower, tub, or near toilet
- ☐ Hair dryers, curling irons, electric shavers, and hand razors are not stored securely
- ☐ Hand and power tools and large equipment (e.g. lawnmower, snowblower) are not stored securely
- ☐ Knives and other sharp utensils are not stored securely
- ☐ Night lights are not installed between bedroom and bathroom
- ☐ Poisonous chemicals are not stored securely
- ☐ Poisonous plants are present
- ☐ Refrigerator is not cleaned out regularly
- ☐ Slippery surfaces don’t have textured stickers to improve traction
- ☐ Someone smokes or drinks
- ☐ Stove does not have hidden gas valve or circuit breaker
- ☐ Throw rugs are present
- ☐ Water temperature is not 120 degrees or less
- ☐ **None of the above.**

Significant Events

Which of the following significant events have you experienced in the past year?

- ☐ Car accident
- ☐ Death of a close friend
- ☐ Death of my spouse
- ☐ Death of another close relative
- ☐ Death of a pet
- ☐ Diagnosed with cancer
- ☐ Elective surgery
- ☐ Emergency surgery
- ☐ Emergency room visit
- ☐ Fall
- ☐ Heart attack
- ☐ Hip fracture
- ☐ Hospital stay
- ☐ Moved to a new home
- ☐ Started having memory problems
- ☐ Started on a new medication
- ☐ Started using a cane, walker or wheelchair
- ☐ Stopped driving
- ☐ Stroke
- ☐ **None of the above.**

Comments:
Any of the above can be very traumatic, either physically or emotionally. Discuss how these events have affected you with your doctor.

Sleep

Which of the following apply to you?

- ☐ After dozing off, sometimes wake up with a "snort"
- ☐ Don't feel rested or refreshed even after a long sleep
- ☐ Feel like I'm getting old too fast
- ☐ Feel paralyzed and panicky when you cannot wake up from a nightmare
- ☐ Feel sleepy and struggle to stay alert, especially during afternoon meetings
- ☐ Feel tired much of the time
- ☐ Frequently doze off at religious services
- ☐ Frequently fall asleep while watching TV
- ☐ Frequently feel depressed
- ☐ Frequently feel sleepy during the day
- ☐ Frequently get heartburn in the middle of the night
- ☐ Frequently have a morning headache
- ☐ Frequently wake with a bad taste in your mouth, or a dry mouth or throat
- ☐ Friends and family say I'm sometimes grumpy and irritable
- ☐ Go to the bathroom more than once after going to sleep
- ☐ Have been told I hold my breath or stop breathing while asleep
- ☐ Have been told I snore
- ☐ Have difficulty concentrating
- ☐ Have fallen asleep at a stop light or stop sign while driving
- ☐ Have fallen asleep while driving
- ☐ Have high blood pressure
- ☐ Have short-term memory problems
- ☐ My neck measures over 17 inches (males) or over 16 inches (females)
- ☐ My sex drive or ability to have sex is diminished
- ☐ My weight is 15 pounds more than it should be
- ☐ Sometimes perspire a lot, especially at night
- ☐ Sometimes wake up with a pounding or irregular heartbeat
- ☐ Toss and turn a lot while asleep
- ☐ Wake up suddenly gasping for breath
- ☐ Wish I had more energy and less fatigue
- ☐ **None of the above.**

Comments:

Five yes answers or more indicate that you may have obstructive sleep apnea (OSA). OSA can lead to a heart attack, stroke, impotence, irregular heartbeat, high blood pressure and heart disease. Treatment is available that doesn't involve surgery or drugs. Sleep tests are simple and painless, and are covered by most insurance policies. According to the National Commission on Sleep Disorders Research (NCSDR), sleep apnea is a life-threatening condition which kills over 38,000 each year.

Talk to your primary care doctor about an evaluation by a sleep specialist (usually a neurologist or pulmonologist) to confirm whether you have sleep apnea and what can be done about it. General info for patients on sleep problems from the NCSDR at http://www.nhlbi.nih.gov/health/public/sleep/index.htm

Symptoms

Which of the following have you experienced or noticed in the past month?

- ☐ Absentmindedness
- ☐ Anxiety or nervousness
- ☐ Bowel incontinence
- ☐ Can't remember things from long ago
- ☐ Can't remember things that happened recently
- ☐ Car accident or unsafe driving
- ☐ Catastrophic reactions or aggressiveness
- ☐ Confusion
- ☐ Decreased emotion
- ☐ Decreased interest in doing things or socialization
- ☐ Delusions
- ☐ Denial of problems
- ☐ Depression or sadness
- ☐ Difficulty with routine chores
- ☐ Disorientation to time and place
- ☐ Don't recognize self in mirror
- ☐ Excessive alcohol intake
- ☐ Falls or other accidents
- ☐ Forget names of family members
- ☐ Get lost taking a walk or driving
- ☐ Diarrhea, nausea, GI upset or indigestion
- ☐ Hallucinations
- ☐ Hearing problems
- ☐ High irritability
- ☐ Inattention to personal hygiene
- ☐ Lose train of thought
- ☐ Misplace, hoard, hide things or rummage through things
- ☐ Pacing or following someone else
- ☐ Paranoia
- ☐ Personality change
- ☐ Poor appetite
- ☐ Poor balance or shuffling
- ☐ Poor concentration or attention span
- ☐ Poor judgment
- ☐ Poor sleep or restlessness at night
- ☐ Reduced ability to express things in writing
- ☐ Reduced ability to name objects or persons
- ☐ Reduced ability to speak or read
- ☐ Reduced ability to understand what's going on around you
- ☐ Reduced ability to use things (such as silverware) properly
- ☐ Repetitive statements or questions
- ☐ Require help with daily tasks
- ☐ Resistant to medical care
- ☐ Severe agitation
- ☐ Sexually inappropriate
- ☐ Shakiness or tremors
- ☐ Socially inappropriate
- ☐ Stiffness or rigidity
- ☐ Tiredness or fatigue
- ☐ Unsteadiness or poor balance
- ☐ Urine incontinence
- ☐ Wandering
- ☐ **None of the above.**

Comments:
Make sure you discuss any troublesome symptoms with your primary care doctor, especially if they are new.