Pre-Visit Questionnaire – Geriatric Center of WNY

Patient sticker ____________________________

1. Please check the best answer for each possible issue:

Issue	Not a problem	Somewhat a problem, but tolerable	Significant problem, but tolerable	Intolerable
Appetite/weight change				
Chest pain or pressure				
Constipation				
Insomnia				
Low energy/fatigue				
Low mood/depression				
Memory				
Overall health/quality of life				
Pain				
Shortness of breath				
Urine leakage				

2. If you have significant or intolerable pain, please choose the average intensity:

Significant, but tolerable 1 2 3 4 5 6 7 8 9 10 Worst pain possible

3. How would you rate your overall health/quality of life now?

Terrible 1 2 3 4 5 6 7 8 9 10 Great

4. What are ONE or TWO main things you wish could be better?

5. Please check which of the following happened since your last visit to this office:

Event	No	Yes	Please explain or give details (e.g. names of health providers seen, medications started or stopped, etc.)
Blood, x-rays or other tests done			
Fall			
Hospitalized			
Medication change/new medication prescribed			
Need medication refill today			
Procedures done			
Seen at an urgent care center or emergency department			
Started a new over-the-counter medication on your own			
Stopped a medication on your own (e.g. side effect, cost)			
Visit to another health provider			
Allergies: Any changes?			

6. What specific things do you need to talk about today with the doctor/Nurse Practitioner/ Physicians Assistant?