RETURN OFFICE VISIT – INTERIM QUESTIONNAIRE

HUNTER HOPKINS CENTER

Name _____ Date _____

Please list your top three concerns for today:

_____
_____
_____

Have you had any hospitalizations since last seen? [ ] No [ ] Yes (give details, including name of hospital):

_____

Have you had any major illness, injuries, or wrecks since last seen? [ ] No [ ] Yes (give details)

_____

Have you had any special medical studies (MRI, EEG, biopsies, endoscopies, etc.) since last seen? [ ] No

[ ] Yes: _____
_____

Have you had an allergic reaction since last seen? [ ] No

[ ] Yes: _____

Have you had any of the following routine studies since last seen (circle the ones you have had):

CBC	Blood chemistry	Thyroid	Diabetes check
ANA (lupus)	Lyme	Sed rate	Urinalysis
Other			

Indicate the severity of your symptoms by marking a carat (**V**) on the 10 point scales below:

Sleep	[___|___|___|___|___|___|___|___|___|___]	Poor Excellent
Fatigue	[___|___|___|___|___|___|___|___|___|___]	None Severe
Cognition problems	[___|___|___|___|___|___|___|___|___|___]	None Severe
Overall Body Pain (without pain meds)	[___|___|___|___|___|___|___|___|___|___]	None Severe
Overall Body Pain (with pain meds)	[___|___|___|___|___|___|___|___|___|___]	None Severe
Orthostatic Intolerance	[___|___|___|___|___|___|___|___|___|___]	None Severe

The Activity Ratio

In an average day, please estimate how many hours you spend:
(HINT: start with sleep, then heavy activity, then light activity…)

Asleep in bed …… _____

Resting ……_____ [ ] R
(sitting or lying quietly)

Doing light or sedentary activity … _____
(lift <20#, carry 10#, walk, stand, push/pull)

Doing moderate or heavy activity … _____ [ ] A
(carry 10-25#, vacuum, rake, shopping)

TOTAL (must add to 24 hours) _____ [ ] Ratio

Functional Capacity

For how long can you sit still (e.g., watch TV)? _____

For how long can you stand in place (e.g., stand in line)? _____

For how long can you stroll or shop leisurely without resting? _____

Do you have difficulty working overhead? [ ] Yes [ ] No
Do you have difficulty manipulating small objects? [ ] Yes [ ] No
Do you have difficulty holding things? [ ] Yes [ ] No
Do you have difficulty kneeling? [ ] Yes [ ] No
Do you have difficulty bending or stooping (e.g. change bed)? [ ] Yes [ ] No
Do you have difficulty getting up from a chair? [ ] Yes [ ] No
Do you have difficulty getting up from the floor? [ ] Yes [ ] No
Do you have trouble getting out of a tub bath? [ ] Yes [ ] No

How much can you lift ? Put an X in the appropriate box, where

INFREQUENT means sporadically or uncommonly, up to occasionally
OCCASIONAL means 1 to 33% of an 8-hour work day
FREQUENT means in excess of 33% of an 8-hour work day

Weight or object	Not at all	Infrequently	Occasionally	Frequently	All day…
5 pounds					
A gallon jug					
10 pounds					
20 pounds					
25# of pet food					
More than 25 pounds					

Cognition

Check the cognitive problems that bother you:

[ ] Concentration (reading a book)
[ ] Comprehension (understanding what you just read)
[ ] Short term memory (forget recent conversations and events)
[ ] Long term memory (forget events in the distant past)
[ ] Calculation (mental math, making change, keeping a checkbook)
[ ] Verbal expression (searching for words, slips of the tongue)
[ ] Disorientation (temporarily lost in even familiar surroundings)
[ ] Confusion (can't remember how to do simple familiar tasks like run the computer, turn on the windshield wipers)

Exercise and Health-Enhancing Activities

Do you have a regular stretching or exercise program? [ ] Yes [ ] No

Describe it: _____

_____

_____

In what health-enhancing activities do you participate (circle or underline activities):

Massage	Acupuncture	Meditation	Ice / heat
Relaxation	Prayer	Visual imagery	Paraffin bath
Tai chi	Yoga	Quai gong	Chiropracty
Pool therapy	Spa / tub soaks	Massager (electric)	

Others _____

Annual Review of Symptoms

In the past 12 months have you experienced any of the following symptoms:

General	
	Unexpected weight loss or gain
	Fevers or feverishness
	Chills
	Night sweats
	Trouble sleeping
	Trouble staying awake
	Change in appetite
	Change in enjoyment of hobbies or sex
Special Senses	
	Change in vision
	Change in sense of smell or taste
	Change in or trouble hearing
	Ringing in your ears
Head & Neck	
	Itchy, watery eyes
	Sneezing or congestion, more than 2 wks
	Facial pain
	Recurrent sore throat or hoarseness
	Trouble swallowing
	Mouth sores (recurring)
	Ear pain
	New type or worsening headaches
	Enlarged lumps or glands in the neck
	Neck pain or stiffness
Chest	
	Chronic cough
	Coughed up blood or rusty phlegm
	Trouble breathing on exertion
	Wheezing
	Awakened with trouble breathing
Heart	
	Pressure, tightness or heaviness in chest
	Heart racing or skipped beats
	Fainted
	Pressure in the throat with exertion
Gastrointestinal System	
	Recurrent nausea or vomiting
	Had food stick on swallowing
	Had intolerance of foods
	Had a change in stool frequency
	Had blood in your stool
	Had mucous in your stool
	Had black or tarry stools
	Had pains in your abdomen
	Had excessive gas
	Had excessive bloating
	Had indigestion or heartburn
	Had acid reflux or water in the throat
	Had diarrhea
	Had constipation
Genitourinary System	
	Had trouble urinating
	Have to urinate more than twice nightly
	Urine stream weaker than last year
	Do you return to the bathroom within 30 minutes of urinating
	Burning on urination
	Genital discharge, sores, or odor
	Pain the pelvic area or genitals
	Pain with intercourse
	Change in menstrual pattern or flow
	Painful menstruation
	Premenstrual tension or PMS
	Hot flashes
	Changes in sexual desire or performance
Musculoskeletal	
	Persistent pain in bones or joints
	Persistent pain in muscles
	Stiffness in joints
	Swelling in joints
	Back pain
	Recurrent sprains
	Muscle spasms or fluttering
Nervous System	
	Balance difficulties
	Numbness, tingling, or weakness
	Incoordination
	Migraine or headaches
	Tremor
	Depression
	Anxiety
	Disorientation or confusion
	Bowel or bladder incontinence
Skin & Skin Structures	
	Changes in texture of skin (dry or oily)
	Loss or breakage of hair
	Unexplained or persistent rash
	Change in size, shape or color of a wart or mole

Check the appropriate box(es):

This questionnaire was completed by the patient [ ], a spouse [ ], a guardian [ ], and/or a friend [ ].

Please sign or initial here to make this an official chart entry: _____

Thank you for taking the time to complete this questionnaire!...