

**GERIATRIC PATIENT HISTORY FORM**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  female  male

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Current Primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_

**Current Health Condition**

When, where and from whom did you last receive medical or health care? \_\_\_\_\_

Reason? \_\_\_\_\_

How did you hear about this clinic: \_\_\_\_\_

List of most important health problems:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

Which of the above problems are of most immediate concern?  
\_\_\_\_\_

In general, compared to others your age, how has your physical health been in the last 12 months:

 Excellent  Good  Fair  Poor**Family History**

If any blood relative had any of the following, please indicate their relationship to you and name the disease on the line provided, following each condition:

Mental illness \_\_\_\_\_ Epilepsy \_\_\_\_\_ Dementia \_\_\_\_\_

Alcohol addiction \_\_\_\_\_ Drug addiction \_\_\_\_\_ Other \_\_\_\_\_

**Hospitalizations and/or Surgeries:** (include reason and dates)

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

**X-rays and Special studies:** (within the last 2 years)

X-rays \_\_\_\_\_

CT or MRI of the Brain \_\_\_\_\_

Other \_\_\_\_\_

**Allergies:** (list any foods, drugs, or other allergens)

\_\_\_\_\_

**Social Assessment:**
**1) Has any of the following happened in the last year? (If yes, describe)**

- Death of spouse \_\_\_\_\_  
 Death of other close family member or friend \_\_\_\_\_  
 Change in health of family member \_\_\_\_\_  
 Change in living situation, divorce or separation, marriage or "pairing up" \_\_\_\_\_  
 Change in financial status \_\_\_\_\_

**2) How often do visitors come to see you?**     Daily     Weekly     Less often     Never

**3) Describe your typical meals:**

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snack/Drinks \_\_\_\_\_

**Functional Status:**
**1) For how long (if at all) has your health limited you in each of the following activities? (Check mark)**

	Limited for more than 3 months	Limited for less than 3 months	Not limited at all
Bending, lifting or stooping			
Cooking meals			
Driving			
Eating, dressing, bathing, or using the toilet			
Managing finances			
The kinds or amounts of vigorous activities you can do, like lifting heavy objects, running, participating in strenuous sports, etc.			
Walking one block			
Walking uphill or climbing stairs			
Working at a job			



**Tell us about you.**

Please check any that apply.

**General**

Weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_ Maximum weight \_\_\_\_\_ When \_\_\_\_\_ Height \_\_\_\_\_

**General**

- Appetite loss
- Fatigue
- Weakness
- Weight gain
- Weight loss

**Skin**

- Dryness
- Itching
- Poor wound healing
- Rash

**Head & Ears**

- Ear discharge
- Ear pain
- Headaches
- Hearing loss
- Ringing in ears

**Cardiovascular**

- Chest pain
- Chest tightness
- Fainting
- Irregular heartbeats
- Leg swelling
- Nighttime shortness of breath
- Palpitations
- Short of breath w/exercise

**Respiratory**

- Cough
- Noisy breathing
- Sleep disturbances
- Snoring
- Wheezing

**Gastrointestinal**

- Abdominal bloating
- Abdominal pain
- Blood in stools
- Bowel habits change
- Bowel incontinence
- Constipation
- Dark stools
- Diarrhea
- Excessive appetite
- Flatus/gas
- Heartburn
- Hemorrhoids
- Nausea
- Trouble swallowing
- Vomiting

**Urinary**

- Bladder incontinence
- Blood in urine
- Frequency
- Hesitancy
- Incomplete emptying
- Nighttime urination
- Painful urination
- Pelvic pain
- Urgency

**Musculoskeletal**

- Arthritis
- Back pain
- Falls
- Gout
- Joint pain
- Joint swelling
- Muscle cramps
- Neck pain
- Stiffness

**Habits:**

What are your main hobbies and interests? List in order of preference, and amount of time spent on each:

1) \_\_\_\_\_

3) \_\_\_\_\_

2) \_\_\_\_\_

4) \_\_\_\_\_

**Do you exercise?** What forms and how often?

1) \_\_\_\_\_

3) \_\_\_\_\_

2) \_\_\_\_\_

4) \_\_\_\_\_

Do you eat 3 meals daily?      Y      N

Read      Y      N

Awaken rested      Y      N

How often?

Sleep Well      Y      N

Been treated for drug dependence      Y      N

Average 6-8 hours sleep      Y      N

Use recreational drugs      Y      N

Nap during day      Y      N

How often?

How often?

Been treated for alcoholism      Y      N

Difficulty sleeping      Y      N

Smoke or chew tobacco      Y      N

Spend time outside      Y      N

How often?

Watch television      Y      N

How many hours a day?

PT NAME

MR #

What else would you like the doctor to know?

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**Thank you for your time and thoughtfulness in completing this intake form.**