



## Geriatric Practice Health History Questionnaire

Welcome to the Wright State Physicians Geriatric Department! We are looking forward to meeting you at your upcoming visit. **Before your visit, please fill out this form and bring it with you to your appointment.** Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. *All questions on this form are optional and will be kept strictly confidential.*

**Is there anything specific you would like us to focus on for your first visit? Please write it on the line below.**

### Allergies

Please list your allergies (medications, food, bee stings, etc.) and your reaction you experienced.

Allergy	Reaction
1.	
2.	
3.	

**Favorite Pharmacy:** \_\_\_\_\_

### Medications

Please list all the medications you are taking. This includes prescribed drugs and over-the-counter drugs (including vitamins, supplements).

Medication Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

## Health Care Team

Please list any other specialist(s) you see for other health conditions (i.e. cardiologist, eye specialist, pulmonologist, podiatrist). Please include their addresses and phone numbers.

Specialist	Name and Contact Information
1.	
2.	
3.	
4.	

## Immunization History (check all that apply)

<input type="checkbox"/> Flu Shot      Date:	<input type="checkbox"/> Pneumonia (Pneumovax 23)      Date:	<input type="checkbox"/> Pneumonia (Pneumovax 23)      Date:	<input type="checkbox"/> Pneumonia (Pneumovax 23)      Date:	<input type="checkbox"/> Pneumonia (Pneumovax 23)      Date:	<input type="checkbox"/> Pneumonia (Pneumovax 23)      Date:
<input type="checkbox"/> Tetanus      Date:	<input type="checkbox"/> Shingles      Date:				

## Past Medical History (check all that apply)

<input type="checkbox"/> Addiction	<input type="checkbox"/> Eye Disorder	<input type="checkbox"/> Neurologic Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Headaches	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Past Infections
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Polycystic Ovarian Syndrome
<input type="checkbox"/> Bleeding/Clotting Problem	<input type="checkbox"/> Heart Valve Disorder/Murmur	<input type="checkbox"/> Prior Blood Transfusion/Chemotherapy
<input type="checkbox"/> Bowel Problem	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Sexually Transmitted Infection
<input type="checkbox"/> Carotid Artery Disease	<input type="checkbox"/> Hospitalizations	<input type="checkbox"/> Skin Conditions
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Kidney/Bladder Problems	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Liver Disease/Hepatitis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Musculo/Skeletal Problems	<input type="checkbox"/> Other:

## Past Surgical History

Surgery	Reason	Year	Hospital
1.			
2.			
3.			



### Social History

<b>Education</b> <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> High School <input type="checkbox"/> 2 Yr College <input type="checkbox"/> 4 yr College <input type="checkbox"/> Post Graduate  <b>Occupation:</b>	<b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single	<b>Sexual</b> <u>Are you sexually active?</u> Y/N  <u>What is your sexual orientation?</u> <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual	<b>Living Situation</b> <u>I live in a:</u> <input type="checkbox"/> House <input type="checkbox"/> Apartment/Condo <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Home Facility  <u>Do you live with anyone? Who?</u>
<b>Exercise</b> <input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	<b>Caffeine</b> <input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy # cups/cans per day?	<b>Alcohol</b> <u>Do you drink alcohol?</u> Y/N  <u>How often?</u> <input type="checkbox"/> Occasionally <input type="checkbox"/> Less than 3 times/week <input type="checkbox"/> More than 3 times/week	<b>Tobacco</b> <u>Do you currently use tobacco?</u> Y/N <input type="checkbox"/> Cigarettes ___ pks/day <input type="checkbox"/> Chew ___/day <input type="checkbox"/> Cigars ___/day  <u>If not now, did you ever use tobacco?</u> # Years Used _____ Quit date: _____

### Daily Living Function

Can you perform the following functions without help? (Please check the option that applies to you)

Function	Yes, with ease	Yes, with difficulty	No, with some help	No, someone does this for me
Toilet				
Feeding				
Dressing				
Grooming				
Ambulation				
Bathing				
Using the telephone				
Shopping				
Cooking				
Housekeeping				
Laundry				
Driving				
Managing Medications				
Handling Finances				

**Do you have any advanced care directives set up (i.e. Power of Attorney, Living Will)?**

- No
- Yes. Please bring in a copy of your advanced care directives and we will scan them into your chart.
  - Provide name of your power of attorney(s) (POA), if available:
    1. Medical Care POA:
    2. Financial POA:

**Is there anything else you would like your health care provider to know? Please write in the space below.**