Wright State Physicians

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, pulmnologist, podiatrist). Please include their addresses and phone numbers.

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

Immunization History (check all that apply)

☐ Flu Shot Date:	☐ Pneumonia (Prevnar 13 ← newest guideline recommendation) Date:
☐ Tetanus Date:	☐ Shingles Date:
☐ Pneumonia (Pneumovax 23) Date:	

Past Medical History (check all that apply)

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

Past Surgical History

Surgery	Reason	Year	Hospital
1.			
2.			
3.			

Preventative/Wellness

Screening	Year(s)/Location(s)	Result(s)
Colon Cancer Screening (please check all that apply): ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Stool Card		
Osteoporosis Screening (DEXA Bone Scan)		
Breast Cancer Screening (Mammograms)		
Cervical Cancer Screening (PAP Smears)		

Family Health History

			Significant Health Problems in my Family									
Relation	**Age**	**Alive? Y/N**	**Alcoholism**	**Arthritis**	**Cancer**	**Dementia**	**Depression**	**Diabetes**	**Heart Disease**	**Hypertension**	**Osteoporosis**	**Stroke**
Grandmother (Maternal)												
Grandfather (Maternal)												
Grandmother (Paternal)												
Grandfather (Paternal)												
Father												
Mother												
Brother/Sister												
Brother/Sister												
Other:												

Social History

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