

Thank you for taking the time to complete the following questionnaire about your health.

By completing this questionnaire you are assisting your health care team in providing a comprehensive and complete review of your health.

We ask that you complete this form in advance of your meeting with the nurse and doctor to ensure that your visit is guided to meet your needs.

We will ask questions about common health issues, and since some problems (e.g., depression) can be missed, we will ask about your mood and way of thinking, too.

Please complete this form to the best of your ability, and use the last page to tell us about anything else that you would like to share with your health care team.

Geriatric Periodic Health Exam – Patient Form (Office Use)

Patient Name	Date of Birth [yyyymmdd]	HCN

Health Concerns:

Please list your current health concerns:

Medication(s):

Please list **all** of your current medications (incl. non-prescription and herbal remedies):

Name	Dose	How Often	Name	Dose	How Often
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Please answer the following questions (check your response for all yes / no questions):

General Health:	<i>Office Use</i>
How would you describe your own health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Has there been a recent change (within the past 90 days) in your health? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you visited the Emergency Room in the past 30 days ? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you been admitted to the hospital within the past 90 days ? Yes <input type="checkbox"/> No <input type="checkbox"/> => If yes, please provide comments:	
Do you have pain that affects our quality of life? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you take your medications as recommended? Yes <input type="checkbox"/> No <input type="checkbox"/> => If no, please provide comments:	
When was your last flu shot ?	Date:

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When was your last tetanus-diphtheria vaccination? Date:	
Do you brush your teeth and floss regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you see a dentist yearly for regular cleaning? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do your gums bleed while brushing your teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have difficulties with your vision? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has it been more than two (2) years since you had a complete eye exam? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have difficulties with your hearing? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has there been a change in your weight? No change <input type="checkbox"/> Weight increase <input type="checkbox"/> / Weight decrease <input type="checkbox"/>	
Has there been a change in your appetite? No change <input type="checkbox"/> Appetite increase <input type="checkbox"/> / Appetite decrease <input type="checkbox"/>	
Do you have any problems with involuntary loss of water/urine? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Mental Health:	Office Use
Are you basically satisfied with your life? Yes <input type="checkbox"/> No <input type="checkbox"/>	*For scoring purposes 2 or more bolded answers over the next 5 questions indicates a need for follow up
Do you often get bored? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you often feel helpless? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you prefer to stay at home rather than going out and doing new things? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you feel pretty worthless right now? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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Patient Name	Date of Birth [yyyymmdd]	HCN

Do you have problems sleeping? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have difficulties with your memory? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Lifestyle:	Office Use
Do you drink alcohol? Yes <input type="checkbox"/> => If yes, how much (# of drinks/week)? _____ No <input type="checkbox"/>	
Do you currently smoke or have you ever smoked? Yes <input type="checkbox"/> => If yes, how many packs/day? _____ => For how many years? _____ No <input type="checkbox"/>	
If you smoke now, are you thinking of quitting? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you exercise regularly? Yes <input type="checkbox"/> => If yes, how often / what type of activity? No <input type="checkbox"/>	
Do you have a Power of Attorney? => For personal care <input type="checkbox"/> => For property <input type="checkbox"/>	
If yes, have you discussed your Powers of Attorney with those close to you? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Falls/Mobility (Safety):	Office Use
Have you had a fall within the last 12 months ? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did you seek medical attention as a result of a fall? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have a fear of falling? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Geriatric Periodic Health Exam – Patient Form (Office Use)

Patient Name	Date of Birth [yyyymmdd]	HCN

Activities:	Office Use												
Do you have any difficulties with everyday activities? Yes <input type="checkbox"/> No <input type="checkbox"/> => If yes, please indicate the areas where you have difficulty:													
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;"><input type="checkbox"/> Eating</td> <td style="width: 25%; border: none;"><input type="checkbox"/> Dressing</td> <td style="width: 25%; border: none;"><input type="checkbox"/> Meal preparation</td> <td style="width: 25%; border: none;"><input type="checkbox"/> Laundry/ Housekeeping</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Toileting</td> <td style="border: none;"><input type="checkbox"/> Grooming</td> <td style="border: none;"><input type="checkbox"/> Shopping</td> <td style="border: none;"><input type="checkbox"/> Banking</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Walking</td> <td style="border: none;"><input type="checkbox"/> Bathing</td> <td style="border: none;"><input type="checkbox"/> Use of Telephone</td> <td></td> </tr> </table>	<input type="checkbox"/> Eating	<input type="checkbox"/> Dressing	<input type="checkbox"/> Meal preparation	<input type="checkbox"/> Laundry/ Housekeeping	<input type="checkbox"/> Toileting	<input type="checkbox"/> Grooming	<input type="checkbox"/> Shopping	<input type="checkbox"/> Banking	<input type="checkbox"/> Walking	<input type="checkbox"/> Bathing	<input type="checkbox"/> Use of Telephone		
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<input type="checkbox"/> Walking	<input type="checkbox"/> Bathing	<input type="checkbox"/> Use of Telephone											
Driving:	Office Use												
Do you drive? Yes <input type="checkbox"/> No <input type="checkbox"/>													

Comments:

Please use this space to comment on anything else that you would like to communicate to your primary care team.

Thank you for assisting us in providing a comprehensive Periodic Health Exam.