Please return the completed questionnaire 1-2 Weeks
<u>BEFORE</u> your appointment.

Thank you for completing this questionnaire. Answer the questions to the best of your knowledge and complete ALL pages.

To access a link to the paperwork scan here with your cell camera:

Failure to complete the questionnaire may result in canceling and rescheduling the appointment.

EMAIL TO: chebeaumontgeriatriccenter@corewellhealth.org
Fax: 248-551-1245

Kindly notify us **<u>ASAP</u>** if you are unable to make the appointment as there is a waiting list for our Geriatric physicians. If the paperwork is submitted and complete you are eligible to move up if there is a cancellation.

Only the patient and 1 guest will be permitted in the appointment. Any additional guests may be asked to remain in the lobby.

Please arrive 15 minutes PRIOR to your scheduled appt.
Please call us if we can be of any further assistance. 248.551.0615

Corewell Health

Geriatric Assessment Services
New Patient Health Questionnaire

Today's Date: _____ Appointment Date:_____

Patient Name: _____ Age: _____

◆ ◆

Name of person who completed this form:_____
Relationship to patient:_____

◆ ◆

Who is your primary doctor?
Name: _____
Address: _____
Phone: _____

Please list any other doctors you see regularly.

Doctor's Name	Specialty	Reason Seen	Phone #	Address

What do you consider to be your most important problem to be addressed at this visit?
_____
_____
_____
_____

Do you have any allergies to medications, food, environment, etc.?

State what allergic to:	Describe allergic reaction:

Gather all your prescription and non-prescription medicines (pills, capsules, eye drops, nasal sprays, laxatives, ointments, pain relievers, vitamins, nutritional supplements, etc.) that you are currently using. Separate those that you use regularly (even once a week) from those you use only as needed.

List all items you use regularly at this time.

Medication	Dose	Frequency	Reason taken	How long taken

List those used “as needed” at least twice in the past year.

Medication	Dose	Frequency	Reason taken	How long taken

OFFICE USE ONLY: DATE:	Med changes: YES NO
Signature PT:	RN:

Please list all current and past Medical problems.

Medical problem	Date of onset	Circle Past and/or Current	Date(s) and Name(s) of Hospital(s) (if applicable)	Family History (if yes indicate relationship, mother, father, brother, etc)
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
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		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		
		Past Current		

Please list all surgeries you have had, including those in childhood.

Surgery	Date	Reason	Hospital

Family History

Please complete the following:

Number of brothers: Living _____ Deceased _____
Number of sisters: Living _____ Deceased _____
Number of children: Living _____ Deceased _____

Children's names: _____
_____

Mother: ☐ Living ☐ Deceased:
Age/Cause of death _____
Father ☐ Living ☐ Deceased:
Age/Cause of death _____

Please note below the illnesses known for your parents, grandparents, brothers, sisters, children.

Illness	Family member(s) who had this
Heart Problems	
High Blood Pressure	
High Cholesterol	
Cancer (note type)	
Bleeding Problem	
Diabetes	
Asthma	
Kidney Disease	
Thyroid Disease	
Stroke	
Nervous/Mental Problems	
Down’s Syndrome	
Dementia	
Other:	

SOCIAL HISTORY:

Have you **ever** smoked or chewed tobacco?

☐ No ☐ Yes ➔ ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing Tobacco

Are you currently smoking?

☐ No - How many years ago did you quit? _____
How many years did you smoke? _____
How much did you smoke per day? _____

☐ Yes - How many years have you smoked? _____
How much do you smoke per day? _____

Do you currently drink alcohol (liquor, beer, wine)?

☐ No, never drank alcohol ☐ No, but used to drink alcohol

☐ Yes ➔ How many alcoholic drinks (including beer & wine) do you have:
In a week? _____
In a month? _____

Have you ever used illegal drugs or illegally used prescription drugs:

☐ No,

☐ Yes (provide details):_____

Have you ever had a blood transfusion?

☐ No

☐ Yes ➔ Note when & why_____

How many cups of caffeinated beverages (coffee, tea, cola) do you drink daily: _____

Have you had occupational exposure to:

	No	**Yes**	**Details:**
Arsenic			
Asbestos			
Lead			
Loud noises			
Mercury			
Industrial solvents			
Fumes			
Dust			
Radiation			
Other (list)			

Have you been exposed to hobby hazards (e.g. solvents)?

☐ No ☐ Yes (provide details):_____

Sleep

Do you have trouble sleeping? ☐ No ☐ Yes

What time do you go to bed? _____What time do you go to sleep?_____

How often do you wake up to go to the bathroom? _____

Do you wake up other times also? ☐ No ☐ Yes (describe) _____

Do you have trouble going back to sleep after awakening? ☐ No ☐ Yes

What time do you awaken in AM? _____

What time do you get up out of bed for the day? _____

Do you feel rested when you get up most days? ☐ No ☐ Yes

Do you take naps during the day/evening? ☐ No ☐ Yes

Do you have Day/Night reversal? ☐ No ☐ Yes
(Sleep during day, up at night)

Have you ever been told that you snore? ☐ No ☐ Yes

Stress

Do you have any concerns about stress (job, marriage, family problems, etc.)?

☐ No,
☐ Yes (provide details):_____

Weight concerns

Do you have any concerns about your weight?

☐ No,
☐ Yes (provide details):_____

Nutrition

Has your food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?

☐ No ☐ Yes ➔ ☐ Mild appetite loss
☐ Moderate appetite loss
☐ Severe appetite loss

Do you follow a special diet? ☐ No ☐ Yes ➔ describe_____

Describe a typical:

Breakfast: _____

Lunch: _____

Dinner: _____

How many servings of the following do you have in an average day?

Meat: _____ Fruit: _____ Vegetable: _____
Dairy: _____ Caffeine: _____ Sweets:_____

How many cups of fluid do you drink in an average day?

☐ Less than 3 cups
☐ 3 to 5 cups
☐ More than 5 cups

Do you add salt to your food or heavily salt food while cooking? ☐ No ☐ Yes

Exercise

Do you currently participate in any regular activity or exercise program to maintain or improve your physical fitness?

☐ No ☐ Yes ➔ Note below activity & how often done:

If you ride a bike, do you wear a helmet?

☐ Do not ride bike
☐ No. Ride bike without helmet
☐ Yes. Wear helmet when riding

Transportation

What is your usual form of transportation?

☐ Drive my own car ☐ Take a bus ☐ Walk
☐ Ride with relative/friend ☐ Take a cab ☐ Other:_____

Check the box that best describes your use of seat belts.

☐ Always use ☐ Sometimes use ☐ Never use

If you DO NOT drive:

Did your ever drive? ☐ No ☐ Yes
If yes, When did you stop driving? _____
Why did you stop driving? _____If you DO drive:
Have you had any accidents? ☐ No ☐ Yes, describe:
_____

Have you ever gotten lost? ☐ No ☐ Yes, describe:
_____

Miscellaneous

Who is your main support person in a time of need? (Name & relationship)

_____

Describe the activities of a typical day for you.

_____

_____

What do you do for enjoyment? (activities, hobbies, interests, etc.)

_____

What is your religious denomination? _____

Living Arrangements

Which of the following best describes your residence? (Check one)

☐ Apartment ☐ Mobile Home
☐ Condominium ☐ Assisted Living Residence
☐ House ☐ Other: _____

Do you: ☐ Pay rent ☐ Pay mortgage ☐ Own/no current cost

Is your home: ☐ one level (ex. ranch) ☐ two levels (ex. colonial)

Bedroom on: ☐ 1st floor ☐ 2nd floor
Bathroom on: ☐ 1st floor ☐ 2nd floor
Laundry on what level? _____

With whom do you live? (Check all that apply)

☐ Alone ☐ With child or other family member
☐ Spouse/partner ☐ Other: (state name & relationship)
_____

Do you have any pets? ☐ No ☐ Yes, describe: _____

Do you employ someone to provide care or assist you at home?

☐ No ☐ Yes ➔ How many ____ hours/day ____ days/week

Is this sufficient to meet your needs? ☐ No ☐ Yes

Do you get help from family members or friends in your home?

☐ No ☐ Yes ➔ How many ____ hours/day ____ days/week

Is this sufficient to meet your needs? ☐ No ☐ Yes

Do you provide care or assistance for a family member or friend?

☐ No ☐ Yes, describe: _____

Please check appropriate box regarding the following Activities of Daily Living:

Task	Doesn't need assist.	Needs some assist.	Needs total assist.	If need help, who helps? (Name/relationship)
Taking bath/shower				
Getting dressed				
Getting out of bed				
Getting out of chair				
Getting to toilet				
Going up/down stairs				
Walking short distances				
Walking long distances				
Feeding self				
Using the telephone				
Taking medicine properly				
Grocery shopping				
Preparing meals				
Doing housework				
Doing "handyman" work				
Doing laundry				
Managing money/ checkbook				

Personal Safety

Do you feel unsafe about anything in your relationships, home environment or neighborhood? (May include concerns of abuse or neglect) ☐ No ☐ Yes, describe:

_____

Marital Status

Are you currently:

☐ Married (spouse's name:_____ ☐ Widowed
☐ Divorced/separated ☐ Single/never married

How long have you been married, divorced, or widowed? _____

Ethnicity:_____

Where were you born (State, Country)?_____

Primary language you speak/read/write:_____

Other languages you are fluent in:_____

Work & Education History

Are you: ☐ Retired ☐ Presently working:
☐ Part-time ☐ Full-time

Describe your present or past occupation (who worked for, what type job done, how long worked, etc.).

_____

_____

Check box next to any of following you were exposed to when working:

☐ loud noise (without protective earwear) ☐ fumes
☐ toxic substances ☐ dust
☐ radiation ☐ other: _____

Years of Education:

Grade school: 1 2 3 4 5 6 7 8
High school: 1 2 3 4
College: 1 2 3 4 5+ Field of study_____
Grad School 1 2 3 4 5 6 7+ Field of study_____

REVIEW of SYSTEMS:
Check all medical conditions you have now or have had in the past.

General:

Now	Past	Skin
☐	☐	Rashes
☐	☐	Itching
☐	☐	Dryness
☐	☐	Skin cancer
☐	☐	Shingles
☐	☐	Cellulitis- where?_____

Now	Past	Head/Eyes/Ears/Nose/Throat
☐	☐	Recurrent Headaches
☐	☐	Head injury/concussion
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Macular degeneration
☐	☐	Blurred vision
☐	☐	Double vision
☐	☐	Sensitivity to light
☐	☐	Poor night vision
☐	☐	Eye pain
☐	☐	Watery eyes
☐	☐	Dry eyes
☐	☐	Wear glasses
☐	☐	Hearing loss
☐	☐	Hearing aid ☐ right ear ☐ left ear
☐	☐	Ringing in ears
☐	☐	Ear pain
☐	☐	Earwax buildup
☐	☐	Nosebleeds
☐	☐	Sinus problems
☐	☐	Seasonal allergies
☐	☐	Runny nose
☐	☐	Change sense of smell
☐	☐	Change of taste
☐	☐	Dentures ☐ full ☐ partial ☐ upper ☐ lower

Now	Past	Other
☐	☐	Fatigue
☐	☐	Anemia
☐	☐	Clotting/bleeding problems
☐	☐	Fevers
☐	☐	Chills
☐	☐	Night sweats
☐	☐	Falls
☐	☐	Cancer-where/when?
☐	☐	Teeth problems
☐	☐	Mouth/throat pain
☐	☐	Hoarseness
☐	☐	Dry mouth
☐	☐	Excess saliva
☐	☐	Problems chewing
☐	☐	Problems swallowing
☐	☐	Neck pain
☐	☐	Neck stiffness

Now	Past	Endocrine
☐	☐	Diabetes
☐	☐	Overactive thyroid
☐	☐	Underactive thyroid
☐	☐	Goiter
☐	☐	Heat/cold intolerance

		Heart
☐	☐	Chest pain(angina)
☐	☐	Chest pressure
☐	☐	Irregular heartbeat
☐	☐	Palpitations
☐	☐	Heart Failure
☐	☐	Night breathing problems
☐	☐	Swelling feet/ankles
☐	☐	Heart murmur
☐	☐	Rheumatic fever
☐	☐	High blood pressure
☐	☐	High cholesterol
☐	☐	High triglycerides

☐ ☐ Heart attack
☐ ☐ Pacemaker

Now Past Vascular
☐ ☐ Phlebitis/DVT
☐ ☐ Varicose veins
☐ ☐ Claudication (leg pain on walking)
☐ ☐ Cramping - where? _____
☐ ☐ Raynaud's disease
☐ ☐ Leg ulcers/sores
☐ ☐ Aneurysm - where? _____

Now Past Lungs
☐ ☐ Shortness of breath
☐ ☐ Persistent cough
☐ ☐ Sputum
☐ ☐ Coughing up blood
☐ ☐ Asthma
☐ ☐ Emphysema/COPD
☐ ☐ Bronchitis
☐ ☐ Pneumonia
☐ ☐ Tuberculosis
☐ Actual
☐ Exposure only

Now Past Gastrointestinal
☐ ☐ Mucus in stool
☐ ☐ Heartburn/indigestion
☐ ☐ Excess belching/gas
☐ ☐ Hiatal hernia
☐ ☐ Ulcer where?_____
☐ ☐ Pancreatitis
☐ ☐ Diverticulosis
☐ ☐ Colitis
☐ ☐ Colon polyps
☐ ☐ Hemorrhoids
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Blood in stool
☐ ☐ Bowel incontinence
☐ ☐ Gallbladder disease
☐ ☐ Cirrhosis of liver
☐ ☐ Hepatitis
☐ ☐ Jaundice (yellow eyes/skin)
☐ ☐ Stomach pain
☐ ☐ Persistent nausea
☐ ☐ Persistent vomiting
☐ ☐ Vomiting blood
☐ ☐ Appetite loss
☐ ☐ Weight loss
☐ ☐ Weight gain

Now Past Breasts
☐ ☐ Lumps
☐ ☐ Cysts
☐ ☐ Pain
☐ ☐ Nipple discharge
☐ ☐ Breast Cancer

Now Past Genitourinary
☐ ☐ Kidney stones
☐ ☐ Bladder/kidney/urine infection
☐ ☐ Blood in urine
☐ ☐ Difficulty urinating
☐ ☐ Pain on urination
☐ ☐ Urinary frequency
☐ ☐ Urinary urgency
☐ ☐ Excess urination
☐ ☐ Urinary incontinence
☐ ☐ Prostate disease
☐ ☐ Sexually transmitted disease
☐ ☐ Sexually active
☐ ☐ Problems with sexual relations

Women only:
☐ ☐ Age at menopause:
☐ ☐ Hysterectomy ☐ Partial ☐ Total
☐ ☐ Abnormal vaginal bleeding
☐ ☐ Vaginal itching
☐ ☐ Vaginal discharge

Now	Past	Musculoskeletal
☐	☐	Arthritis
☐	☐	Bursitis
☐	☐	Sciatica
☐	☐	Osteoporosis
☐	☐	Fracture-where? _____
☐	☐	Muscle aches-where?_____
☐	☐	Joint pain-where? _____
☐	☐	Joint stiffness-where?_____
☐	☐	Joint swelling-where?_____
☐	☐	Gout-where? _____
☐	☐	Difficulty walking
☐	☐	Change in gait (walking)
☐	☐	Use of cane
☐	☐	Use of walker

Now	Past	Brain & Nervous System
☐	☐	Dizzy spells
☐	☐	Speech problems
☐	☐	Trouble Understanding (not related to hearing)
☐	☐	Memory problems For how long? ____
☐	☐	Seizures/convulsions
☐	☐	Stroke/TIA (“Mini- stroke”)
☐	☐	Parkinson’s disease
☐	☐	Tremors (non-Parkinson)
☐	☐	Polio
☐	☐	Meningitis
☐	☐	Numbness/tingling-where? _____
☐	☐	Weakness-where?

Now	Past	Psychological
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Panic attacks
☐	☐	Nervous breakdown
☐	☐	Restlessness
☐	☐	Agitation
☐	☐	Personality change
☐	☐	Hallucinations
☐	☐	Delusions
☐	☐	Paranoia
☐	☐	Suicide threat-when?_____
☐	☐	Suicide attempt-when?_____
☐	☐	Balance problems
☐	☐	Dizzy spells
☐	☐	Syncope (fainting)

Please complete the following to the best of your ability.

Health Care Maintenance Item:	When last completed:
General Physical Exam	
Flu Shot	
Pneumonia Vaccines (Pneumovax, PCV13, PPSV23)	
SHringrix (Shingles Vaccine)	
Tetanus Shot	
TB Skin Test	
Eye Exam	
Hearing Test (Audiogram)	
Hearing Aid Evaluation	
Dental Exam	
Bone Density Exam (DEXA Scan)	
Sigmoidoscopy/Colonoscopy	
Females: Pap Smear	
Females: Mammogram	
Males: Prostate Exam	
Males: PSA (blood test for prostate)	

Pain Please list the location and severity of any pain you are currently experiencing.

Location of Pain	Severity - State number that most accurately describes your pain 0 1 2 3 4 5 6 7 8 9 10 (no pain) (worst pain)

Finances (You may skip any questions you don't wish to answer here)

Which of the following best describes your financial status?

- ☐ Comfortably able to afford all necessities (food, clothing, housing, transportation, medications)
- ☐ Able to afford necessities with careful budgeting
- ☐ Barely able to afford basic needs
- ☐ Unable to afford the necessities

Please check box next to all current sources of income.

- ☐ Social Security
- ☐ SSI
- ☐ Pension
- ☐ Savings
- ☐ Investments
- ☐ Salary (Paycheck)

Do you receive any additional assistance to meet your financial needs?

☐ No ☐ Yes (check those that apply)

- ☐ from family/friends
- ☐ Medicaid
- ☐ Food Stamps
- ☐ Other: _____

Please check all insurances you have.

☐ Medicare ☐ MediGap (supplemental, ex. Blue Cross, AARP)
☐ Medicaid ☐ Other: _____

Do you have prescription coverage from your insurance?

☐ No ☐ Yes ➔ Amount of co-pay: _____

Legal

Do you have an Advance Medical Directive, Living Will or Durable Power of Attorney for Healthcare (DPOA-HC)?

☐ No ☐ Yes - please note your Patient Advocate's information here:
Advocate's Name: _____
Address: _____
Phone: _____

Do you have a legal guardian?

☐ No ☐ Yes - please note guardian's information here:
Guardian's Name: _____
Address: _____
Phone: _____

If you have an Advance Medical Directive, Living Will/DPOA-HC or legal guardian please bring a copy of the document to your appointment.

◆ ◆

Please note below any additional medical information you feel is important.

_____
_____
_____
_____
_____

For Clinic Use Only:

_____ _____
Fellow Signature/Date Attending Signature/Date

Please remember to bring the following items with you to your appointment.

All your medical insurance cards. (Medicare, Blue Cross, AARP, etc.)
All of your medications, including vitamins, supplements and over the counter (non-prescription) medications.
A copy of your Durable Medical Power of Attorney papers (if you have one).
A copy of your living will or advance directives (if you have one).
A copy of your legal guardian papers (if you have one).
This completed form if you have not already mailed it to us!

☞ **Please return this completed form in the envelope provided as soon as possible.**
Email: chebeaumontgeriatriccenter@corewellhealth.org

Fax 248-551-1245

The information will be reviewed by the Geriatric Clinical Nurse to assure that we are ready for your appointment. This will enable us to make your first appointment as complete and time efficient.

Allot 2-4 hours for the first appointment for a complete assessment.

Thank you for taking the time to fill out this form as completely as possible. This information is vital to our comprehensive geriatric assessment process. We look forward to meeting you and being a part of your health care team. Please call us if we can be of any further assistance. 248.551.0615

Corewell Health