

Geriatric Patient Health History Questionnaire

Please complete this questionnaire as accurately as possible. This information is confidential and will help us provide the best care. This form is designed to be printed and filled out.

1. Personal Information

Full Name:

Date of Birth (MM/DD/YYYY):

Current Age:

Phone Number:

Address:

Today's Date:

2. Emergency Contact & Support

Emergency Contact Name:

Relationship to Patient:

Emergency Contact Phone:

Who lives with you? (e.g., Alone, Spouse, Child, Caregiver):

3. Medical History & Chronic Conditions

Please indicate if you have a history of the following conditions (Write "Yes" or "No" and provide details if "Yes"):

High Blood Pressure / Hypertension:

Heart Disease or Stroke:

Diabetes:

Arthritis or Joint Pain:

Osteoporosis or Bone Fractures:

Memory Loss, Dementia, or Alzheimer's:

Depression or Anxiety:

Other Major Diagnoses:

4. Medications & Allergies

Please list all prescription medications, over-the-counter drugs, vitamins, and supplements you currently take:

Medication 1 (Name, Dosage, Frequency):

Medication 2 (Name, Dosage, Frequency):

Medication 3 (Name, Dosage, Frequency):

Medication 4 (Name, Dosage, Frequency):

Medication 5 (Name, Dosage, Frequency):

Drug Allergies (List all and describe reactions):

5. Functional Status & Safety

Do you use any mobility aids? (e.g., None, Cane, Walker, Wheelchair):

Have you had any falls in the past 12 months? (Yes/No, specify how many):

Do you experience difficulty with bathing, dressing, or eating? (Yes/No, explain):

Do you use corrective lenses or hearing aids? (Yes/No, specify):

6. Preventive Care

Please write the approximate year you last received the following:

Flu Vaccine:

Pneumonia Vaccine:

Shingles Vaccine:

Eye Exam:

Hearing Exam:

7. Social History

Do you smoke or use tobacco products? (Yes/No/Former):

Do you drink alcohol? (Yes/No, specify amount per week):

Do you have an Advance Directive or Living Will? (Yes/No):