Stony Brook Medicine

DEPARTMENT OF MEDICINE

Geriatric Intake Form

Patient Name: _____

MR#: _____

DATE: _____

NAME: _____
Last First Middle Initial

Date of Birth: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

Did someone refer you here? □ Yes □ No If yes, please give name: _____

Main reason for your visit today: _____

MEDICAL HISTORY: *(Please check ✓all that apply, and feel free to elaborate under "Additional Information")*

☐ heart disease	☐ emphysema	☐ frequent urinary tract infections	☐ sexually transmitted disease/herpes
☐ osteoporosis	☐ asthma		
☐ heart failure	☐ chronic bronchitis	☐ incontinence	☐ HIV/AIDS
☐ heart murmur	☐ pneumonia	☐ tuberculosis	☐ polio
☐ coronary heart disease	☐ hay fever/allergies	☐ liver disease	☐ kidney stones
☐ rheumatic fever	☐ diabetes	☐ jaundice/hepatitis	☐ kidney disease
☐ rheumatic heart disease	☐ stroke	☐ thyroid disease	☐ prostate disease
☐ high blood pressure	☐ seizure	☐ depression or anxiety	☐ colitis
☐ high cholesterol	☐ anemia	☐ gall bladder disease	☐ diverticulitis
☐ arthritis	☐ bleeding disorder	☐ glaucoma	☐ hemorrhoids
☐ sciatica	☐ gout	☐ cataracts	☐ ulcers
☐ Alcohol/substance abuse	☐ Parkinson's Disease	☐ fracture	☐ head injury
☐ cancer (describe):	☐ blood transfusion (year:)		☐ hernia

ADDITIONAL INFORMATION/OTHER CONDITIONS:

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HAVE YOU RECENTLY NOTICED: *(Please check ✓all that apply)*

☐ fatigue	☐ headaches/migraines	☐ change in bowel habits	☐ vaginal/penile discharge
☐ weight gain/loss	☐ shortness of breath	☐ joint swelling or pain	☐ frequent urine infections
☐ appetite changes	☐ bronchitis/chronic cough	☐ swollen ankles	☐ blood in urine
☐ change in hearing	☐ asthma/wheezing	☐ leg pain	☐ change in urinary habits
☐ ringing in ear(s)	☐ chest pain	☐ varicose veins/phlebitis	☐ easy bruising
☐ difficulty sleeping or concentrating	☐ palpitations/irregular pulse	☐ persistent nausea/vomiting	☐ change in ability to exercise
☐ fainting spells/passing out	☐ sinus trouble	☐ heartburn/indigestion	☐ seizures
☐ failing vision	☐ frequent sore throat	☐ chronic abdominal pain	☐ tremor/hands shaking
☐ eye pain, redness	☐ hay fever/allergies	☐ jaundice/hepatitis	☐ numbness/tingling
☐ double or blurred vision	☐ prolonged hoarseness	☐ diarrhea/constipation	☐ muscle weakness
☐ eye infections	☐ difficulty swallowing	☐ bloody stools	☐ recurrent back pain
☐ mouth sores	☐ rashes/hives	☐ hemorrhoids	☐ cold/numb feet
☐ recurrent nose bleeds	☐ eczema/psoriasis	☐ dizzy spells	☐ foot pain
☐ depression/nervousness	☐ falls/unsteady walking	☐ memory loss	☐ recent hair loss
☐ insomnia	☐ loud snoring	☐ swollen glands	☐ incontinence *(urine or stool)*

HOSPITALIZATIONS:

Reason for Hospitalization	Hospital	Date(s)

SURGERIES:

Surgical Procedure	Hospital	Date(s)

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CURRENT MEDICATIONS: *(Include prescriptions, vitamins, herbals, and over-the-counter medications)*

Name of Drug	Dose (Strength)	Times/Day

ALLERGIES: (include allergies to medications, dyes, contrast material)

DRUG	REACTION

SOCIAL HISTORY:

Occupation: _____

If you are retired, what date did you retire? _____

Do you live alone? _____ Or with others (please list)? _____

Do you smoke? ☐ Yes ☐ No If yes, how much?_____For how long? _____

If you are a former smoker, when did you quit? _____

Alcohol use: ☐ Yes ☐ No If yes, amount: _____

Do you exercise? ☐ Yes ☐ No If yes, what type? _____

How often?

Do you use illicit substances? ☐ Yes ☐ No

Baby boomers (those born between 1945 and 1965) make up 75% of Hepatitis C virus cases in the U.S. Most people with Hepatitis C don't know they are infected. Hepatitis C is a virus that is now curable.

If you were born between 1945 and 1965, please check this box if you do NOT want to be screened for Hepatitis C ☐

FAMILY HISTORY: List diseases each may have had *(Especially Diabetes, cancer, heart disease, dementia and strokes)*

Mother:	
Father:	
Brother(s):	
Sister(s):	
Child(ren):	
Grandparents:	

WHEN WAS YOUR LAST:

Dental Visit:

Ophthalmology Visit (eye doctor):

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HAVE YOU EVER HAD:

Flu Vaccine:	☐ Yes	☐ No	☐ Don't know	If yes, when?	_____
Pneumonia Vaccine:	☐ Yes	☐ No	☐ Don't know	If yes, when?	_____
Tetanus Shot:	☐ Yes	☐ No	☐ Don't know	If yes, when?	_____
Tetanus Diphtheria Pertusis Vaccine:	☐ Yes	☐ No	☐ Don't know	If yes, when?	_____
Shingles Vaccine:	☐ Yes	☐ No	☐ Don't know	If yes, when?	_____
Colonoscopy/Fex Sigmoidoscopy:	☐ Yes	☐ No	☐ Don't know	If yes, when?	_____
(Rectal scope to screen for colon cancer)					
Stool Card test for blood:	☐ Yes	☐ No	☐ Don't know	If yes, when?	_____
Bone Mineral Density:	☐ Yes	☐ No	☐ Don't know	If yes, when?	

FOR WOMEN ONLY:

When did menopause begin? _____

Since then, have you noticed any vaginal bleeding? ☐ Yes ☐ No

Do you take Calcium and Vitamin D supplements? ☐ Yes ☐ No Dose: _____

Are you on hormone replacement therapy? ☐ Yes ☐ No Medication: _____

Date of last PAP test _____ Result (normal or abnormal): _____

Have you ever had a mammogram? ☐ Yes ☐ No If so, when was it last done? _____

Childbirth-Related: *Please give the number of:*

Pregnancies: _____ Children: _____ Miscarriages: _____ Abortions: _____

FOR MEN ONLY: *Have you ever had…*

Rectal exam (digital/finger)?	☐ Yes	☐ No	If so, when?	_____
A PSA (Prostate Specific Antigen) blood test?	☐ Yes	☐ No	If so, result?	

DIETARY HISTORY:

Usual Adult Weight:	Any change in weight in the past 6 months?	☐ Yes	☐ No
Appetite:	☐ Good ☐ Fair ☐ Poor		
Are you on a special diet?			
Any food allergies? List:			

Do you wear dentures? ☐ Yes ☐ No

Do you have any trouble chewing? ☐ Yes ☐ No

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OTHER CONCERNS:

Has anyone close to you physically/emotionally/financially hurt or abused you?	☐ Yes	☐ No
Are there other issues you would like to discuss with your doctor today?	☐ Yes	☐ No

Please list the names and telephone numbers of other physicians who take care of your medical problems (e.g., psychiatrist, ophthalmologist, gynecologist, urologist, etc.):

Name	Specialty	Telephone Number

Please list the name and telephone number of the person you would like us to contact in the event of an emergency:

Please list the name and telephone number of the pharmacy you usually use:

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Please circle the appropriate answer:

1. Can you get to places out of walking distance…
   2 - without help (can travel alone on buses, taxis, or drive own car);
   1 - with some help (need someone to help you or go with you when traveling); or
   0 - are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?

2. Can you go shopping for groceries or clothes (assuming you have access to transportation)…
   2 - without help (taking care of all shopping needs yourself);
   1 - with some help (need someone to go with you on all shopping trips); or
   0 - are you completely unable to do any shopping?

3. Can you prepare your own meals…
   2 - without help (plan and cook full meals yourself);
   1 - with some help (can prepare some things, but unable to cook full meals yourself); or
   0 - are you completely unable to prepare any meals?

4. Can you do your housework…
   2 - without help (can scrub floors, etc.);
   1 - with some help (can do light housework, but need help with heavy work); or
   0 - are you completely unable to do any housework?

5. Can you handle your own money…
   2 - without help (write checks, pay bills, etc.);
   1 - with some help (can manage day-to-day buying, but need help managing your checkbook and paying your bills); or
   0 - are you completely unable to handle money?

6. Can you use the telephone…
   2 - without help, including looking up numbers and dialing;
   1 - with some help (can answer phone or dial operator in an emergency, but need a special phone or help in looking up numbers or dialing); or
   0 - are you completely unable to use the telephone?

7. If you take medications, are you able to take your own medication…
   2 - without help (correct doses, time intervals, etc.);
   1 - with some help (reminding, preparation, etc.); or
   0 - are you unable to take your own medication?

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Please circle the appropriate answer...

1. Are you able to dress and undress yourself…
   2 - without help | 1 - with some help | 0 - unable

2. Are you able to take care of your appearance, i.e. grooming…
   2 - without help | 1 - with some help | 0 - unable

3. Can you shower or bathe…
   2 - without help | 1 - with some help (need help getting in and out of the tub, for example) | 0 - unable

4. Are you able to feed yourself…
   2 - without help | 1 - with some help | 0 - unable

5. Are you able to climb stairs to get to your home…
   2 - without help | 1 - with some help (cane, another person, etc.) | 0 - unable

6. Are you able to walk…
   2 - without help | 1 - with some help (cane, walker, another person) | 0 - unable *(wheelchair or bedridden)*

7. If you cannot walk, can you get from one place to another, i.e., toilet, bed, wheelchair…
   2 - without help | 1 - with some help | 0 - unable

8. Are you able to control your urination…
   2 - always | 1 - sometimes | 0 - never | NA *(have catheter)*

9. Are you able to control your bowel movements…
   2 - always | 1 - sometimes | 0 - never | NA *(have colostomy)*

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Please circle the appropriate answer...

1. How has your health been in the past month?
   2 - good 1 - fair 0- poor

2. During the past month, how many weeks have you been sick in bed?
   2 - none 1 - less than two weeks 0 - two or more weeks

3. During the past month, how many days have you been in a hospital, rehabilitation facility, or nursing home?
   2 - none 1 - less than two weeks 0 - two or more weeks

4. How may falls have you had in the past six months?
   2 - none 1 - one fall 0 - more than one fall

5. During the past month, have you required personal assistance at home to help you function?
   2 - no 1 - yes; by family, friend; sometimes 0 - yes; by agency, family, friend; daily

6. Who provides this assistance?
   Name:
   Relationship:
   Phone:

7. Do you have any physical handicap(s) that limit(s) your daily activities?
   2 - no 1 - yes, some limitations 0 - yes, severe limitations

8. How much physical pain have you had over the past month?
   2 - none 1 - mild - moderate 0 - severe

9. Do you ever feel that you are losing your balance when you walk?
   2 - no 1 - yes

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Do you use any of the following aids all or most of the time? If not, do you need such aid? *(Please check all that apply)*

AIDS	YES	NO	NEED
Cane			
Walker			
Wheelchair			
Wrist Splints			
Leg Brace			
Back Brace			
Artificial Limb			
Hearing Aid(s)			
Colostomy Equipment			
Catheter			
Commode			
Glasses/Contact Lens			
Dentures			
Hospital Bed			
Toilet Bars			
Tub Bars/Tub Seat			
Other			
Specify:			

Have you retired? ☐ Yes ☐ No If yes, what year did you retire? _____

What is your usual form of transportation? *(check all that apply)*

☐ drive my own car: ☐ *days only* ☐ *days and nights* ☐ *local* ☐ *long distance*

☐ use public transportation

☐ rely on friends/family

Do you have difficulty getting around the house?

☐ no difficulty ☐ a little difficulty ☐ a lot of difficulty

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling Down, depressed or hopeless	0	1	2	3

Is there someone who would give you help if you were sick? If so, please give name:

Name: _____ Phone #: _____

Relationship: _____

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Are you active in/do you attend any religious, civic or senior citizen organizations?

Do you participate in an Adult Day Program? ☐ Yes ☐ No

Do you currently receive Meals-On-Wheels? ☐ Yes ☐ No

Do you have a home attendant? ☐ Yes ☐ No

Do you have a home health aide? ☐ Yes ☐ No

Do you have a housekeeper? ☐ Yes ☐ No

If so, how frequently do they come? Days per week: _____ Hours per day: _____

If so, how is the cost covered? ☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ Private Pay ☐ VA Benefits ☐ Other

Are you followed by a long-term home care program or private home care agency? ☐ Yes ☐ No

If yes, which one? _____

Where do you live? _____

☐ Own my home ☐ Live with relatives (in a private home)

☐ senior housing ☐ adult home ☐ apartment ☐ other: _____

How many stairs do you have to climb to gain access to your home/apartment? _____

Do you share your home with anyone? ☐ Yes ☐ No If yes, with whom? _____

Do you have an emergency call button or lifline device? ☐ Yes ☐ No

If your answer is no, but you would be interested in obtaining one, check here: ☐

Does your income cover your needs? ☐ Yes ☐ No Does it cover extras? ☐ Yes ☐ No

Does your insurance cover your prescription medications? ☐ Yes ☐ No ☐ I have EPIC

Do you have a Living Will (advanced directives)? ☐ Yes ☐ No

Have you named a "Durable" Power of Attorney? ☐ Yes ☐ No

If yes, whom? (Name, Address, and Phone Number): _____

Whom would you want to make medical decisions for you if you were unable to do so? (Health Care Proxy):

(Name, Address, and Phone Number): _____

Completed by: _____ Relationship to Patient: _____ Date: _____

Reviewed by (physician): _____ MD ID#: _____ Date: _____