PROVIDING QUALITY GERIATRIC HEALTH CARE IN THE COMMUNITY

Patient Name: ______________________________________ Date of Birth: ________________

Medical History

Check all that apply, and fill out the lower portion if necessary.

Condition	Now	Past	Condition	Now	Past
Allergies			Hemorrhoids		
Alzheimer's Disease			High Blood Pressure		
Anemia			Kidney Problems		
Anxiety			Leg Swelling		
Arthritis			Liver Problems		
Asthma			Migraines		
Bladder Problems			Pain: __________________________		
Incontinence			Prostate Problems		
Urinary Tract Infection			Skin Disease		
Blood Clots			Stomach Problems		
Blood Vessel Problems			Nausea		
Bowel Problems			Stomach Ulcer		
Constipation			Vomiting		
Cramps			Stroke		
Diarrhea			Thyroid Disease		
Irritable Bowel Syndrome			Trouble Sleeping		
Rectal Bleeding			Tuberculosis		
Breast Problems			Ulcer: ________________________		
Bronchitis			Reproductive Problems		
Cancer: ________________			Abnormal Pap Smear		
Dementia			Hysterectomy		
Depression			Sterility, Genetic		
Diabetes (Type 1 or 2)			Sterility, Optional		
Emphysema			Vaginal Bleeding		
Epilepsy/ Seizures			Vision Problems		
Fatigue or Tiredness			Cataracts		
Fractures: ______________			Glaucoma		
Gall Bladder Problems			Weight Gain		
Hearing Problems			Weight Loss		
Heart Problems			Other:		

Patient has a family history of:

____
____
____
____

Allergies:

____
____
____
____

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Patient Name: ______________________________________ Date of Birth: ________________

Personal Habits

Alcohol Use:	_____	Times a week	Meals:	_____	Meals a day
Coffee/Tea:	_____	Times a Day	Sleep:	_____	Hours a night
Exercise:	_____	Times a week	Tobacco:	_____	Packs a day

Family History

Mother:	Living ____	Deceased	(Cause of death:______________________)
Father:	Living ____	Deceased	(Cause of death:______________________)
Sibling(s):	Living ____	Deceased	(Cause of death:______________________)
Children:	Living ____	Deceased	(Cause of death:______________________)

Social History

Former/ Current Occupation: ____

Marital Status(circle one) : Married Divorced Single Widowed

Please include a copy of the most current medication sheet available. Ensure that this medication list has drug names, dosage amounts, and dosage instructions. If you do not have a MARS (Medicine Administration Record Sheet), Please create a handwritten list. Failure to provide this information may delay the processing of your enrollment package.

Former Primary Care Physician: ____

Address: ____

Phone: ___________________________ Fax: __________________________________

Surgical/Hospitalization History

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<u>Please provide any other information you feel is important for us to know.</u>

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