



Stony Brook
Medicine

DEPARTMENT OF MEDICINE
Geriatric Intake Form

Patient Name: _____

MR#: _____

DATE: _____

NAME:

_____ Last

_____ First

_____ Middle Initial

Date of Birth: _____

ADDRESS: _____

HOME _____

WORK _____

PHONE: _____

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")*

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

ADDITIONAL INFORMATION/OTHER CONDITIONS:



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

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

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:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Pneumonia Vaccine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Tetanus Shot:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Tetanus Diphtheria Pertusis Vaccine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Shingles Vaccine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Colonoscopy/Fex Sigmoidoscopy: <i>(Rectal scope to screen for colon cancer)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Stool Card test for blood:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	If yes, when?	_____
Bone Mineral Density:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there other issues you would like to discuss with your doctor today?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 0 - unable
 (need help getting in
 and out of the tub, for
 example)
- 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 0 - unable
 (cane, another person,
 etc.)
- 6. Are you able to walk...
 2 - without help 1 - with some help 0 - unable
 (cane, walker, another *(wheelchair or bedridden)*
 person)
- 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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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 lifeline 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: _____