Cooley Dickinson Medical Group Geriatrics New Patient Information Form

Welcome to Cooley Dickinson Medical Group Geriatrics

General Information:

Name: _____ Date of Birth: _____

Preferred Name: _____ Language Spoken: _____

What gender were you assigned at birth?: □ Male □ Female

What is your current gender?: □ Male □ Female □ Non-Binary/Genderqueer

Primary Care Provider: _____

Office Phone Number: _____ (if known)

Pharmacy Name and Location: _____

Name of Person Filling out this Form: _____

Relationship to Patient: _____

Person who should be contacted for follow up appointments:

Name: _____

Address: _____

Phone #: _____

What are your goals for this visit?

_____
_____
_____
_____

Any problems or concerns that you would like the doctor to know about before your visit?

_____
_____
_____
_____
_____

DO YOU NEED / HAVE HELP (check all that apply):	
□ Bathing	□ Moving in and out of bed or chair
□ Dressing	□ Continence: control over urinatation/defecation
□ Toileting	□ Feeding – gets food from plate into mouth

DO YOU EMPLOY SOMEONE TO PROVIDE CARE OR HELP YOU IN YOUR HOME?		
□ Yes How many hours a day / week?		□ No

DO YOU GET HELP FROM A FAMILY MEMBER OR FRIEND IN YOUR HOME?	
□ Yes If so, with what?	□ No

DO YOU PROVIDE CARE FOR A FAMILY MEMBER?	□ Yes	□ No

DO YOU USE A:	□ Cane	□ Walker	□ Wheelchair

HAVE YOU HAD ANY FALLS IN THE PAST YEAR?					□ Yes	□ No
If yes, how many?		When?		Injuries?		

HOW WOULD YOU DESCRIBE YOUR SLEEP?

Past Medical History

Which medical conditions do you have or have had in the past? (check all that apply)

EYE AND EAR PROBLEMS	KIDNEY & URINARY TRACT PROBLEMS
□ Cataracts	□ Kidney disease
□ Glaucoma	□ Prostate disease
□ Macular degeneration	□ Frequent urinary infections
□ Hearing loss / hearing aid	□ Urinary incontinence

LUNG PROBLEMS	NERVOUS SYSTEM PROBLEMS
□ Asthma	□ Stroke. When?
□ COPD	□ Dementia / Alzheimer's Disease
□ Bronchitis	□ Parkinson's Disease

HEART PROBLEMS	BONE & JOINT PROBLEMS
□ Heart attack. When?	□ Arthritis
□ Heart failure	□ Osteoporosis
□ High blood pressure	□ Fractured hip, wrist, spine (circle). When:
□ Irregular heart beats / arrhythmias	□ Gout

Past Medical History (continued)

GASTROINTESTINAL PROBLEMS	OTHER HEALTH PROBLEMS
□ Ulcers	□ Anemia
□ Heartburn	□ Hernia
□ Diverticulitis	□ Thrombosis (blood clots)
□ Liver disease / cirrhosis	□ Cancer. Where?
□ Hepatitis	□ Depression
□ Polyps	□ Sexual problems
□ Gallbladder disease	□ Other, specify:

GLAND PROBLEMS	
□ Diabetes	□ Thyroid Disease

List surgeries (operations). Use additional page, if needed:

DATE	SURGERY (OPERATION)

List Other Hospitalizations. Use additional page, if needed.

DATE	REASON

List all medicines that you use (Prescriptions, Non-Prescriptions, Natural Products) OR you can bring in your own list from home instead.

REMEMBER to bring all your medications to your appointment

Name of medication	What strength?	How do you use it? (How many? How many times a day?)
Example: Tylenol	*500 mg.*	*1 pill 3 times a day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Do you have any drug allergies? If yes, specify below :

NAME OF DRUG	**REACTION**

Social History:

Where were you born / raised?	
What is your level of education?	

Which of the following best describes your residence? (check one)	
□ Single-family house	□ Senior resident / Independent living
□ Condo or apartment	□ Assisted living facility
□ Live with other in their home, condo or apartment	□ Other, specify:

Social History: (Continued)

Sexual Orientation (check one)	☐ Bisexual/Queer
☐ Heterosexual/Straight	☐ Other
☐ Gay/Lesbian/Homosexual	

Are you currently (check one)	Employment history (check one)
□ Married	□ Retired / Not working
□ Divorced / Separated	□ Working part-time
□ Widowed	□ Working full-time
□ Single / Never married	What was your primary occupation?
□ Living with significant other. Who?	

How many children do you have?		
Are you in regular contact with your children?	□ Yes	□ No

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?		Have you ever smoked cigarettes? □ Yes □ No
□ Daily		If currently smoking: How much do you smoke? _____packs per day
□ Almost daily (4 to 6 times a week)		
□ 1 to 3 times a week		If no longer smoking: How much did you smoke? _____packs per day
□ Less than 1 time a week		
□ Never		For how many years did you smoke?
If you drink alcohol, has anyone ever been concerned about your drinking? □ Yes □ No		How long ago did you quit?
		Did you ever use drugs such as marijuana, cocaine or IV drugs? □ Yes □ No
Are you concerned about your alcohol intake? □ Yes □ No		If yes, what?
		Do you still use drugs such as marijuana or IV drugs? □ Yes □ No

Advanced Care Planning:

Do you have a Health Care Proxy?		Who would you like to be involved
□ Yes		in your care?
Please bring a copy		□ Primary care physician
□ No		□ Family:
Do you have a completed MOLST form?		
□ Yes Please bring a copy		□ Friends:
□ No		

Health Maintenance:

How do you think your health compares to most people of your age?		Have you had a hearing test within the last two years?
□ Very good		□ Yes □ No
□ Good		Have you had an eye exam within the past year?
□ Fair		
□ Bad		□ Yes □ No
□ Very bad		Have you seen a dentist in the last year?
Has food intake declined over the past 3 months?		
□ Yes □ No		□ Yes □ No
Have you lost weight over the last year?		When were you last seen by your dentist?
□ Yes □ No		
Have you gained weight over the last year?		Have you had:
□ Yes □ No		□ Pneumonia vaccine. When:
Do you feel sad or depressed most days?		□ Tetanus shot. When:
□ Yes □ No		□ Shingles vaccine. When:
Do you feel you have more memory problems than most people at your age?		Do you currently participate in any regular activity to improve or maintain your physical fitness?
□ Yes □ No		
Do you feel safe at home?		□ Yes. Specify:
□ Yes □ No		□ No

REVIEW OF SYSTEMS Check all that apply**:**

Constitutional ☐ None ☐fever ☐ tiredness/fatigue
Eyes ☐ None ☐ glasses ☐ blurred vision ☐ double vision
Ears/Nose/Throat ☐ None ☐sinus infection ☐deafness ☐ ear ringing ☐ difficulty swallowing
Heart ☐ None ☐ chest pain ☐ irregular heartbeat
Lungs ☐ None ☐ shortness of breath ☐ wheezing ☐ cough
Abdomen ☐ None ☐ diarrhea ☐ constipation ☐ pain ☐ bowel incontinence
Urinary ☐ None ☐ incontinence ☐ difficulty voiding ☐ infections ☐ blood in urine
Musculoskeletal ☐ None ☐ pain ☐ arthritis
Skin ☐ None ☐ rash ☐ skin ulcers ☐ sores ☐ lumps/masses
Neurologic ☐ None ☐ tingling ☐ balance problems ☐ dizziness
Behavioral ☐ None ☐ depression ☐ anxiety ☐ hallucinations ☐ mental illness
Blood/lymphatics ☐ None ☐ blood clots ☐ easy bruising ☐ leg swelling
Other:_____

Any other information that you would like to share: