



Name: _____	HEALTH QUESTIONNAIRE
. _____ Last Name, First Name, MI	GERIATRIC REVIEW
Drug Allergies: _____	
Pharmacy #: ()	

Home Phone No _____
 Address: _____
 Sex: F ___ M ___ Age: _____ Marital Status: M S W D Ht: _____ Wt: _____
 Lifetime Occupation: _____
 Religious Preference: _____

Local Primary Care Physician: _____
 Address: _____ Phone: _____

Level of Education (check One): ___ Elem ___ Jr. High ___ High School ___ College ___ Advanced

Do you have a Living will or Power of Attorney? Y ___ N ___ May we have a copy?: Y ___ N ___

Do you have a Health Care Proxy? Y ___ N ___ Name: _____
 Address: _____ Phone: _____

First Person to notify in case of emergency: Name: _____
 Address: _____ Phone: _____

What relationship is this individual to you: _____

Second Person to notify in case of emergency: _____
 Address: _____ Phone: _____

What relationship is this individual to you: _____

Person you wish us to contact for appointment scheduling or test results (if other than yourself):
 Name: _____ Phone: _____

What relationship is this individual to you?: _____

What is your current living arrangement? Please check all that apply:
 _____ Alone _____ Spouse only _____ Spouse and others
 _____ Other Relatives _____ Non Relatives

Where do you live at present time?
 _____ At home _____ Assisted living _____ Nursing home
 _____ Housing for older adults _____ Other (explain) _____

* Have you had any **major accidents** in the past? Please explain:

* List all **allergies** and **reactions** (nausea, difficulty breathing, rash etc):

* When was your last: **MAMMOGRAM** _____ **PAP SMEAR** _____
COLONOSCOPY/SIGMOIDOSCOPY: _____

* Immunizations- Include Year: **PNEUMOVAX:** _____ **INFLUENZA:** _____
TETANUS: _____ **HEPATITIS B:** _____ **OTHER:** _____
BONE MINERAL DENSITY : _____ **PSA:** _____ **Cholesterol** _____

Medication - name	Strength and frequency	Medication – name	Strength and frequency
1		6	
2		7	
3		8	
4		9	
5		10	

Vitamins : _____

Alternative Medicines and health food supplements: _____

Habits: _____ Tobacco use Packs per day _____ Number of Years _____
 _____ Alcohol use Drinks per week _____ Number of Years _____

Family History: (if more siblings, please add on separate page)

Mother: If alive current age _____ If passed on, age at death _____ Cause of death _____
 Other Illnesses _____

Father: If alive current age _____ If passed on, age at death _____ Cause of death _____
 Other Illnesses _____

Brother: If alive current age _____ If passed on, age at death _____ Cause of death _____

