Totem Lake Family Medicine

Adult Health Questionnaire - Age 65 and Over

Name_____ DOB_____/_____/_____DATE_____/_____

IDENTIFICATION

Usual occupation (work done most of life even if retired):_____

Who lives in your household (relationship, ages, names):_____

_____

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married Number of Children_____

MEDICAL HISTORY: List all past surgeries and illnesses requiring hospitalization

Problem	Year	Problem	Year
1._____		4._____	
2._____		5._____	
3._____		6._____	

List all prescription medications and bring them with you to your appointment:

Medication	Dosage	Medication	Dosage
1._____		6._____	
2._____		7._____	
3._____		8._____	
4._____		9._____	
5._____		10._____	

Please list any **non-prescription** medications you take (aspirin, laxative, Geritol, vitamins, etc.)

1._____ 4._____

2._____ 5._____

3._____ 6._____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, name drug and describe reason_____

Do you get yearly flu shots? ☐ Yes ☐ No

When was your last tetanus shot?_____ ☐ Not sure

Have you ever received a pneumonia vaccination? ☐ Yes ☐ No ☐ Not sure

FAMILY HEALTH: Please check all of the following that have occurred in your family (parents, brothers sisters, aunts, uncles, grandparents)

☐ Diabetes
☐ Breast cancer
☐ Bowel or colon cancer
☐ Other cancer
☐ Alcoholism
☐ Depression
☐ Suicide
☐ Heart Attack
☐ Stroke
☐ Other illness/condition_____
_____
_____

PERSONAL HEALTH HISTORY: Please **check** if you have ever had any of the following:

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Breast cancer
- ☐ Other cancer
- ☐ Arthritis
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema or asthma
- ☐ Broken bones
- ☐ Seizures (epilepsy)
- ☐ Stroke or near stroke
- ☐ Alcoholism
- ☐ Hepatitis or liver disease
- ☐ Tuberculosis
- ☐ Positive TB skin test
- ☐ "High" blood cholesterol
- ☐ Thyroid condition
- ☐ Blood transfusion
- ☐ Other illness_____

BODY SYSTEMS REVIEW: What are your health concerns at this time?

_____

_____

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Check below any of the following that apply to you: **Physician Comments**

- ☐ Lost or gained 10 lbs. in the last year without trying _____
- ☐ Major changes in your skin (moles, etc) _____
- ☐ Trouble with your eyes or vision _____
- ☐ Trouble with your ears or hearing _____
- ☐ Chest pain or heaviness with activity _____
- ☐ Shortness of breath, hoarse or prone to coughing _____
- ☐ Trouble chewing, swallowing, heartburn, stomach pain or ulcers _____
- ☐ Blood or recent changes in your bowel movements _____
- ☐ Difficulty urinating or holding your urine _____
- ☐ Any sexual problem you wish to discuss _____
- ☐ Back, joint, or muscle problems _____
- ☐ Feet or ankles often swollen, other foot problems _____
- ☐ Have severe headaches _____
- ☐ Get dizzy often _____
- ☐ Tire easily _____
- ☐ Trouble walking or maintaining your balance _____
- ☐ Fallen to the ground in the past year _____
- ☐ Trouble sleeping _____

WOMEN ONLY

- ☐ Breast lumps or nipple discharge _____
- ☐ Vaginal or menstrual bleeding _____
- ☐ Taking or have previously taken estrogen supplements _____
- ☐ Do monthly breast self-exam _____

When was your last mammogram?_____ ☐ Never had one ☐ Uncertain

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Please **check** if you have experienced any of the following in the last year:

- ☐ Marriage
- ☐ Divorce
- ☐ Personal illness or injury
- ☐ Change of residence
- ☐ Death of spouse or partner, or close friend
- ☐ Major illness or death in your family
- ☐ Retirement or change in job

How much in the **last month** were you distressed or bothered by…

(Check the correct box for each statement below)

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Feeling low in energy or slowed down					
Blaming yourself for things					
Feeling lonely or blue					
Sleep that is restless or disturbed					
Feeling hopeless about the future					
Feeling everything is an effort					
	0	1	2	3	4

HEALTH HABITS AND RISKS

	Yes	No	Physician Comments
1. Do you exercise regularly?	☐	☐	
If yes, what exercise?_____			
How many times per week?_____			
For how long?_____			
2. Do you smoke cigarettes now?	☐	☐	
If you quit, please indicate month and year_____			
If you smoke now, how many cigarettes per day?_____			
How long have you smoked?_____			
3. Are you overweight?	☐	☐	
4. Do you drink alcoholic beverages?	☐	☐	
If yes, how many per week? ☐ 7 or less ☐ 8-14 ☐ 15 or more			
(1 drink = I glass or beer, wine or hard liquor drink)			
If yes, have you ever:			
Felt the need to cut down on your drinking?	☐	☐	
Felt annoyed by criticism of your drinking?	☐	☐	
Had guilty feelings about your drinking?	☐	☐	
Taken a morning eye opener?	☐	☐	
5. When was your last complete eye exam?_____			
6. Do you use seatbelts?	☐	☐	
7. Is the hot water from your tap too hot to hold your hand under comfortably?	☐	☐	
8. Does your house have: a smoke detector?	☐	☐	
a fire extinguisher?	☐	☐	

FUNCTIONAL ASSESSMENT/PLANNING FOR THE FUTURE

Do you have difficulty with:	Yes	No
Dressing	☐	☐
Bathing	☐	☐
Getting in and out of bed	☐	☐
Using the bathroom	☐	☐
Eating	☐	☐
Doing household chores	☐	☐
Shopping	☐	☐
Driving	☐	☐
If you do not drive, how do you get where you want to go? _____		

	Yes	No
If you need help or someone to talk with, do you have someone you can call?	☐	☐
Do you manage your own finances?	☐	☐
Do you have a will?	☐	☐
Have you signed a living will or power of attorney?	☐	☐
If no, do you know where to get assistance in acquiring one?	☐	☐