**Neogeriatrics**

**2823 Aaronwood Ave. NE**

**Massillon, OH 44646**

***PATIENT INFORMATION:***

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| Social Security Number: |  | Date: |
| Last Name: |  First Name: |  Middle Initial: |
| Date of birth: |  |  |
| Address: |  |  |
| City: |  State:  |  Zip: |
| Home Phone: |  Preferred to be called at this # |  Yes No |
| Cell Phone: |  Preferred to be called at this # |  Yes No |
| Gender: (circle one) Male  | Female |  |
| Email address: |  |  |
| Who referred you: |  Family Physician: |  |
| Marital Status: Single Married |  Divorced Separated Other |  |
| Employment Status: Employed  | Unemployed Retired Student Other | Employer: |
| Emergency contact: |  Emergency contact phone #: |  |

***INSURANCE INFORMATION:***

**Primary Insurance Secondary Insurance**

|  |  |
| --- | --- |
| Insurance Company: | Insurance Company: |
| Subscriber or ID# | Subscriber or ID# |
| Group Name: | Group Name: |
| Group Number: | Group Number: |
| Policy holder’s information: | Policy holder’s information: |
| Name: | Name: |
| SSN: | SSN: |
| DOB: | DOB: |
| Relationship to patient: | Relationship to patient: |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questionnaire**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PAST MEDICAL HISTORY** |

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| ❏ Heart Problems❏ High Blood Pressure❏ Sleep Apnea❏ Asthma❏ Anesthesia/Sedation Problems❏ Emphysema Stroke❏ Thyroid ProblemsTuberculosis❏ Osteoporosis | ❏ Diabetes❏ Epilepsy❏ Stomach Ulcers❏ Jaundice or Hepatitis❏ Kidney Disease❏ Pneumonia❏ Anemia❏ Glaucoma❏ Cataracts | ❏ Other significant Illnesses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ Previous surgeries and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ Have you ever been in the hospital overnight? When and for what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ Broken bones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **SOCIAL HISTORY** |

Do you smoke? ❏ Yes (How many per day?)\_\_\_\_\_\_\_\_\_\_\_\_\_ ❏ No ❏ Quit (How long ago?)\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? ❏ Yes (How many per week?)\_\_\_\_\_\_\_\_\_\_\_\_\_ ❏ No ❏ Quit (How long ago?)\_\_\_\_\_\_

Do you use drugs for reasons that are not medical? ❏ Yes ❏ No (If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

How many cups/glasses of caffeinated beverages do you drink per day? \_\_\_\_\_\_\_\_\_

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| **REVIEW OF SYMPTOMS:** Please review the following list and check any symptoms you have experienced in the last two weeks. |

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| **Gastrointestinal**❏ Nausea/Vomiting❏ Abdominal pain❏ Diarrhea❏ Heartburn**Endocrine**❏ Diabetes❏ Thyroid disease❏ Excessive thirst**Musculoskeletal**❏ Joint pain or swelling❏ Decreased range of motion❏ Muscle weakness/ tenderness**Hematologic/Lymphatic**❏ Anemia❏ Abnormal bleeding❏ Enlarged lymph nodes | **Constitutional**❏ Recent weight gain lb. \_\_\_\_❏ Recent weight loss lb. \_\_\_\_❏ Fatigue or weakness❏ Fever❏ Night sweats**Cardiovascular**❏ Pain in chest❏ Irregular heart beat❏ Swollen legs or feet**Respiratory**❏ Cough❏ Wheezing (asthma)❏ Shortness of breath❏ Sputum production | **Eyes**❏ Pain or redness❏ Loss of vision❏ Dry or Itchy eyes**Ears–Nose–Mouth–Throat**❏ Nasal Congestion❏ Seasonal allergies❏ Rhinitis❏ Sinus pain❏ Sore throat❏ Ringing in ears or hearing loss❏ Hoarseness**Integumentary (skin or breast)**❏ Easy bruising❏ Redness/Rash/Hives❏ Sun sensitive (sun allergy)❏ Tightness❏ Nodules/lumps |
| **Neurological System**❏ Headaches❏ Dizziness or fainting❏ Loss of consciousness❏ Memory loss or confusion**Psychiatric**❏ Excessive worries/Anxiety❏ Depression❏ Agitation❏ Difficulty with sleep | **Immunologic**Hepatitis B Vaccination ❏ Yes ❏ NoPneumonia Shot ❏ Yes ❏ NoFlu Shot within last year ❏ Yes ❏ No**Genitourinary**❏ Urinary complaints❏ Discharge❏ Flank pain❏ Urine frequency❏ Pain urination | ***For Women Only:***Date of last period if applicable?Number of pregnancies?Number of miscarriages?Mammogram within last 24 mo. ❏ Yes ❏ NoDXA bone scan completed ❏ Yes ❏ No❏ Urinary incontinence❏ Discharge❏ Flank pain❏ Urine frequency❏ Pain urination |

Other symptoms not mentioned above (Please be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FAMILY HEALTH HISTORY** |

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| **Disease**  | **Yes** | **No** | **Which relative?** | **Age at diagnosis** |
| **High blood pressure** |  |  |  |  |
| **Heart disease** |  |  |  |  |
| **Diabetes** |  |  |  |  |
| **Stroke** |  |  |  |  |
| **Asthma** |  |  |  |  |
| **Breast Cancer** |  |  |  |  |
| **Colon or Rectal Cancer** |  |  |  |  |
| **Other type of cancer: Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |  |
| **Mental Problem**  |  |  |  |  |
| **Alcohol or Drug Problem** |  |  |  |  |

Are your symptoms related to any injury or illness which resulted from an automobile accident or other incident?

❏ Yes ❏ No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Current medications including over the counter medications, vitamins, and herbal treatments:** |

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| Name of medication | Dose | Frequency | Prescribing Doctor |
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Do you have any known drug allergies? YES NO If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When was your most recent flu vaccine?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Acknowledgement of Medical Information:** |

I have reviewed Patient or family member signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the above medical information with the patient.

Provider’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_