**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**

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| --- | --- |
| 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 Problems  Tuberculosis  ❏ 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 ❏ No  Pneumonia Shot ❏ Yes ❏ No  Flu 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 ❏ No  DXA 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_