

# 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. _____	_____
_____	_____	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. _____
_____	5. _____
3. _____	6. _____

Are you allergic to any medications?  Yes  No

If yes, name drug and describe reaction \_\_\_\_\_

Do you get yearly flu shots?  Yes  No

When was your last tetanus shot? \_\_\_\_\_  Don't know

Have you ever received a pneumonia vaccination?  Yes  No  Don't know

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

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Depression	<input type="checkbox"/> Other illness/condition _____
<input type="checkbox"/> Bowel or colon cancer	<input type="checkbox"/> Suicide	_____
<input type="checkbox"/> Other cancer	<input type="checkbox"/> Heart Attack	_____

## Adult Health Questionnaire - Age 65 and Over (cont.)

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Depression            | <input type="checkbox"/> Hepatitis or liver disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breast cancer       | <input type="checkbox"/> Emphysema or asthma   | <input type="checkbox"/> Positive TB skin test      |
| <input type="checkbox"/> Other cancer        | <input type="checkbox"/> Broken bones          | <input type="checkbox"/> "High" blood cholesterol   |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Seizures (epilepsy)   | <input type="checkbox"/> Thyroid condition          |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Stroke or near stroke | <input type="checkbox"/> Blood transfusion          |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> 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 if any of the following apply to you.
- 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 change 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 problems with your feet or foot care \_\_\_\_\_
  - Have severe headaches
  - Get dizzy often
  - Tire easily
  - Trouble walking or maintaining your balance
  - Fallen to the ground in the past year
  - Trouble sleeping

**Physician Comments**

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**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

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Marriage                   | <input type="checkbox"/> Change of residence                         | <input type="checkbox"/> Major illness or death in your family |
| <input type="checkbox"/> Divorce                    | <input type="checkbox"/> Death of spouse or partner, or close friend | <input type="checkbox"/> Retirement or change of job           |
| <input type="checkbox"/> Personal illness or injury |  |  |

