Geriatric Periodic Health Exam Patient Print Form

Thank you for taking the time to complete the following questionnaire about your health in advance of your meeting with the health care team to ensure that your visit is guided to meet your needs.

By completing this questionnaire to the best of your ability, you are assisting in providing a comprehensive and complete review of your health.

Use the last page to tell us about anything else not mentioned in the form.

Geriatric Periodic Health Exam
Patient Self-Report - Print Form

eFit electronic Frailty Interprofessional Toolkit

Centre for Studies in Aging & Health — Creating, Applying & Sharing Knowledge — Providence Care

Patient Name: First name Last name

Birthdate: YYYY-MM-DD

Evaluation Date:

Health Concerns Please list your current health concerns:

General Health: please check the box in front of the statements which are true

How would you describe your health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ There been a change in your health in the past 90 days

☐ You visited the Emergency Room in the past 30 days? If checked, why?

☐ You have been admitted to the hospital within the past 90 days. If checked, why?

Sensory Loss

☐ You have difficulties with your vision.

☐ You have difficulties with your hearing

☐ It has been more than two (2) years since you had a complete eye exam?

☐ It has been more than two (2) years since you had a complete hearing test

Digestion

☐ You have gained weight

☐ You have lost weight

☐ Your appetite has increased

☐ Your appetite has decreased

Bladder & Bowel

☐ You have problems with loss of urine

☐ You use continence aids (pads, diapers)

☐ You experience constipation

☐ You experience diarrhea

☐ There has been a change in your regular bowel habits. If so please describe >>

Dental

☐ You brush your teeth and floss regularly

☐ You see a dentist annual cleaning

☐ Your gums bleed while brushing your teeth

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Lifestyle

☐ You drink alcohol ☐ # drinks/week

☐ You currently smoke or have you ever smoked? ☐ # cigarettes/day

☐ You smoke now, but are thinking of quitting ☐ # marijuana joints/day

☐ You exercise regularly

Please describe how often and what type of activity:

Substitute Decision Maker (SDM) & Power of Attorney (PoA)

☐ You have a Substitute Decision Maker for Personal Care ☐ You have a **PoA** for Finances

☐ You have discussed your wishes with your SDMs, PoA and those close to you

Falls/Mobility (Safety)

☐ You have had a fall within the last 12 months? ☐ You required medical attention as a result of a fall?

☐ You have a fear of falling? ☐ You are currently still driving

Activities ☐ You have any difficulties with everyday activities

If yes, please indicate which of the activities below you struggle with:

☐ Eating ☐ Toileting ☐ Bathing ☐ Grooming ☐ Dressing

☐ Walking ☐ Banking ☐ Shopping ☐ Meal preparation

☐ Using the telephone ☐ Laundry/ Housekeeping

Vaccinations: Please provide dates for the following: (YYYY-MM-DD)

Last flu shot?

Last Pneumococcal vaccination?

Last Zostavax® (vaccine for shingles)

Last tetanus-diphtheria vaccination

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Mental Health

- ☐ You are satisfied with your life?
- ☐ You often feel helpless?
- ☐ You feel worthless right now?
- ☐ You have difficulties with your memory?
- ☐ You have trouble finding words?
- ☐ You often get bored?
- ☐ You prefer to stay at home rather than going out and doing new things?
- ☐ You have problems sleeping?
- ☐ You have trouble communicating your wishes to people?
- ☐ You have trouble recalling names?

Medications

Medications Please list **all** current medications (include over-the-counter and herbal remedies:)

Name	Dose	Frequency

Do you take your medications as recommended? If no, please provide comments as to why:

Comments: Please provide any other concerns you may have about your current health status: