FAU MEDICINE
FLORIDA ATLANTIC UNIVERSITY

FAU Medicine Geriatric Consult

IDENTIFICATION

Name _____ Date _____

Sex _____ Age _____ Date of Birth _____

CONTACT FOR APPOINTMENTS, RESULTS, EMERGENCIES

Name _____ Relationship _____

Street Address _____ Phone _____

City/State _____ Zip Code _____

OTHER HEALTH CARE PROVIDERS

Who do you see for your health care?

Doctor _____ For what? _____

Doctor _____ For what? _____

Doctor _____ For what? _____

Pharmacy _____ Phone (_____) _____

YOUR GOALS

What are the most important issues you want to address and your most important goals for this visit?

_____

_____

_____

ADVANCE DIRECTIVES **(Please bring a copy of living will or durable POA to your visit for your medical file)**

Have you prepared:

☐ A POWER OF ATTORNEY to handle your financial concerns if you are ever unable to do so yourself?

☐ A DURABLE POWER OF ATTORNEY FOR HEALTH CARE to appoint someone to make decisions about your health care if you are unable to do so yourself?

☐ A LIVING WILL to indicate your wishes about your health care if you could no longer make decisions?

GENERAL HEALTH CONDITION

1. **In general, would you say your health is:**

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **How many times have you been seen in the emergency room in the last year?**

   ☐ None ☐ Once ☐ Twice ☐ 3 times ☐ 4 or more times

3. **How many times have you stayed overnight in a hospital in the last year?**

   ☐ None ☐ Once ☐ Twice ☐ 3 times ☐ 4 or more times

4. **Have you been admitted to a nursing home or assisted living facility in the last year?**

   ☐ Yes ☐ No

5. **Are you currently using durable medical equipment (for example, wheelchair, hospital bed, oxygen, devices to assist with walking)?**

   Device(s) and frequency of use: _____

MEDICAL PROBLEMS

Please list all current medical problems and diagnoses of concern to you:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

Please list below all past <u>non-surgical</u> illnesses you have had requiring hospitalization in the last 10 years:

Year	Hospital Name and Location	Reason

Allergies: _____ **Intolerances**: _____

_____ _____

List all <u>surgeries</u> you have had, minor and major (including cataracts, appendix, etc.)

Year	Hospital Name and Location	Type of Surgery

MEDICATIONS - please list **<u>all</u>** medications you are taking.

Routine prescription medications

Dose	Name of Medication

As needed (PRN) prescription medications

Dose	Name of Medication

Over-the Counter medications including herbals and supplements

Dose	Name of Medication

PREVENTIVE HEALTH

Check any of the following you have had in the past 10 years and give the approximate date:

☐ Flu vaccine	☐ Eye exam
☐ Tetanus shot	☐ Mammogram
☐ Shingles vaccine	☐ Colonoscopy
☐ Pneumovax (pneumonia)	☐ Dental exam
☐ Bone density test	☐ Hearing test

EXERCISE (Please check appropriate box)

	Yes	No
Do you actively exercise 3 or more times a week for at least 20 minutes each time?	☐	☐
Do you do muscle strengthening or stretching exercises 3 or more times a week?	☐	☐

What type of exercise do you normally do? _____

TOBACCO USE	Yes	No
Have you ever smoked cigarettes?	☐	☐

☐ past smoker, year quit _____
☐ current smoker: ☐ pipe ☐ cigar ☐ cigarettes
amount smoked per day _____ number of years smoked _____

ALCOHOL USE	Yes	No
Do you currently drink alcohol?	☐	☐
If yes, please describe: _____		
Do you or someone else have concerns about the amount of alcohol you consume?	☐	☐

DRUG USE	Yes	No
Do you take any opioid medication?	☐	☐
Have you taken opioid medication in the past?	☐	☐
Have you had a problem being dependent on opioids?	☐	☐
Do you use marijuana?	☐	☐
Do you use any other “recreational” drugs?	☐	☐

FAMILY MEDICAL HISTORY

Check if any blood relative had any of the following:

☐ Alzheimer's / Dementia/Memory loss	Who? _____
☐ Anemia	Who? _____
☐ Cancer Type _____	Who? _____
☐ Depression or other mental illness	Who? _____
☐ Diabetes	Who? _____
☐ Heart disease	Who? _____
☐ Osteoporosis	Who? _____
☐ Stroke	Who? _____
☐ Thyroid trouble	Who? _____

FUNCTIONAL ABILITY

Do you need or receive help from another person for any of the following activities?

	Regularly	Occasionally	No
Shopping and errands	☐	☐	☐
Light housekeeping	☐	☐	☐
Doing laundry	☐	☐	☐
Preparing meals	☐	☐	☐
Using transportation	☐	☐	☐
Taking medications	☐	☐	☐
Managing your money	☐	☐	☐

Do you need or receive help from another person for any of the following activities?

	Regularly	Occasionally	No
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Getting out of bed	☐	☐	☐
Getting out of chair	☐	☐	☐
Walking around inside the house	☐	☐	☐
Eating	☐	☐	☐
Using the toilet	☐	☐	☐

Do you still drive? ☐ Yes ☐ No

If yes, have you been involved in any traffic accidents in the past 12 months?

☐ Yes ☐ No

SOCIAL HISTORY

1. **Where were you born?** _____
2. **What was your first language?** ☐ English ☐ Other
3. **How far did you go to school?**

   ☐ Grade school or less
   ☐ High School
   ☐ Professional School
   ☐ College graduate
   ☐ Advanced degree

4. **Are you retired?** ☐ Yes ☐ No
5. **What kind of work do (or did) you do for most of your working career**_____

   _____

6. **Are you**: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married
7. **Number of children** _____ **Where do they live?** _____

   If you don't have any children, who is your closest relative? _____

8. **Do you currently live (check all that apply)**

   ☐ Your own home or condo
   ☐ With a relative? (who) _____
   ☐ An assisted living facility
   ☐ A senior housing or apartment complex
   ☐ Other: (describe) _____

9. **How do you spend your time now? List any special interest and hobbies** _____

   _____

10. **Does someone help you with any activities? If yes, list who and what they help you with and how often and for how long?** _____

    _____

11. **Living Environment**

Do you ever feel unsafe where you live?	☐ Yes	☐ No
Has anyone ever threatened or hurt you?	☐ Yes	☐ No
Has anyone been taking your money without your permission?	☐ Yes	☐ No

SPIRITUALITY

1. Is there anything you would like to share about your religion or culture in order to care for you? _____
2. What is your faith group?

   ☐ Christian
   ☐ Muslim
   ☐ None
   ☐ Jewish
   ☐ Hindu
   ☐ Other _____

REVIEW OF SYMPTOMS

Are you <u>presently</u> having any of the following symptoms?

GENERAL
☐ Poor appetite
☐ Recent weight loss
☐ Have you lost 10 or more pounds over the last months without intending to?
☐ Recent weight gain
☐ Difficulty sleeping
☐ Do you have difficulty falling asleep at night?
☐ Do you snore loudly?
☐ Do you have difficulty staying asleep?
☐ If yes, does something wake you up at night while sleeping (pain, nocturia, cough, noise, etc.)
☐ Do you often feel sleepy during the day?

SKIN
☐ Worrisome mole
☐ Rash
☐ Sores or Ulcers
☐ Other (describe)

RESPIRATORY
☐ Frequent cough
☐ Shortness of breath
☐ Wheezing
☐ Other (describe)

GASTROINTESTINAL
☐ Trouble swallowing
☐ Stomach pain
☐ Indigestion or heartburn
☐ Nausea or vomiting
☐ Change in bowel habits
☐ Diarrhea
☐ Constipation
☐ Blood in bowel movements
☐ Hemorrhoids
☐ Do you lose stool when you do not want to?

URINARY
☐ Frequent urination
☐ Waking at night to urinate
☐ Trouble starting urination or slow stream
☐ Burning or pain when urinating
☐ Blood in urine

INCONTNENCE
Do you have any trouble with your bladder?
☐ No ☐ Yes
Do you lose urine when you do not want to?
☐ No ☐ Yes
Do you ever wear pads or adult diapers?
☐ No ☐ Yes

HEAD, EARS, EYES, NOSE & THROAT
☐ Dizziness or vertigo
☐ Headaches
☐ Sinus trouble
☐ Hearing loss
☐ Poor eyesight (with correction if used)
☐ Glaucoma

CARDIOVASCULAR
☐ Chest pain with walking or exercise
☐ Shortness of breath with walking or at rest
☐ Palpitations
☐ Pain in calves when walking
☐ Swelling of feet or ankles

BONES, JOINTS, MUSCLES
☐ Joint pains (describe)
☐ Lack of strength or weakness
☐ Back pain
☐ Neck pain

NEUROLOGICAL
☐ Loss of balance
☐ Dizziness
☐ Syncope
☐ Seizures
☐ Tremor
☐ Numbness or tingling of hands or feet
☐ Nervousness or anxiety
☐ Blurry or doubled vision
☐ Slurred speech
☐ Other symptoms of TIA

FEET
☐ Pain
☐ Ingrown toenails

GYNECOLOGY (Females)
☐ Breast lumps or discharge
☐ Vaginal itching, discharge or discomfort
☐ Vaginal bleeding

PAIN
Are you experiencing pain or discomfort?
☐ No ☐ Yes

Describe: _____
_____
_____
_____
_____
_____

FALL RISK

Have you fallen in the past year? ☐ No ☐ Yes

- If yes, how many times? _____
- History of previous falls? ☐ No ☐ Yes
- Are you afraid of falling? ☐ No ☐ Yes
- Do you have trouble climbing stairs? ☐ No ☐ Yes
- Do you have trouble getting up from a chair? ☐ No ☐ Yes

MOOD

These questions are about how you feel and how things have been with you during the past 4 weeks. How much of the time during the past 4 weeks…

	All of the time	***Most of the time***	***A good bit of the time***	***Some of the time***	***A little of the time***	***None of the time***
Have you felt downhearted, sad, or depressed?	☐	☐	☐	☐	☐	☐
Have you lost pleasure in doing things?	☐	☐	☐	☐	☐	☐

MEMORY

Do you think you have any problems with your memory? ☐ No ☐ Yes

Do any of your family members or friends think you have problems with your memory?

☐ No ☐ Yes

If yes, please describe: _____
_____
_____