

**JOHN J. GERLACH CENTER FOR SENIOR HEALTH
GERIATRIC ASSESSMENT PRESCREEN**

IMPORTANT! Missing information will cause a delay in scheduling. Please complete ALL information.
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* PLEASE FILL IN THIS QUESTIONNAIRE AND RETURN AS SOON AS POSSIBLE.

Name (Last, First, Middle Initial)										
Address						Primary Insurance		ID #		
City		State		Zip Code		County		Secondary Insurance		ID #
Home Phone			Date of Birth		Age	Sex	Social Security Number		Retirement Date	
Name of Family Member/Friend Accompanying Patient to Appointment							Relationship			
Address						E-mail				
City		State		Zip Code		Home Phone () ()		Work Phone () ()		Cell Phone/ Pager () ()
Name of Family Doctor or the Doctor who Usually Cares for You							Office Phone			
Address						Fax#				
City				State			Zip Code			

OTHER MEDICAL SPECIALISTS SEEN WITHIN LAST 12 MONTHS

- | | |
|--|---|
| <input type="checkbox"/> CARDIOLOGIST
Name _____ | <input type="checkbox"/> PSYCHIATRIST
Name _____ |
| <input type="checkbox"/> ENDOCRINOLOGIST
Name _____ | <input type="checkbox"/> PSYCHOLOGIST
Name _____ |
| <input type="checkbox"/> GASTROENTEROLOGIST
Name _____ | <input type="checkbox"/> PULMONOLOGIST
Name _____ |
| <input type="checkbox"/> NEUROLOGIST
Name _____ | <input type="checkbox"/> UROLOGIST
Name _____ |
| <input type="checkbox"/> ONCOLOGIST
Name _____ | <input type="checkbox"/> OTHER
Name _____ |
| <input type="checkbox"/> OPHTHALMOLOGIST
Name _____ | <input type="checkbox"/> OTHER
Name _____ |
| <input type="checkbox"/> ORTHOPEDIST
Name _____ | <input type="checkbox"/> OTHER
Name _____ |

PRESCRIPTION MEDICATIONS

Pharmacy Name:

Pharmacy Phone #:

MEDICATION NAME	STRENGTH	TIME(S) PER DAY	REASON
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

OVER-THE-COUNTER MEDICATIONS ■ VITAMINS ■ HERBAL SUPPLEMENTS

1.
2.
3.
4.
5.

***** Remember to bring all medications in their original bottles. Thank you.*****

LIST ALL ALLERGIES TO FOODS, MEDICINE OR LATEX

NAME OF FOOD/MEDICATION/LATEX	REACTION

**check yes or no
for each condition**

PLEASE MARK WITH AN "X"

Yes No

- Anxiety
- Arthritis
- Asthma
- Back/Neck Problems
- Bleeding
- Bone or Joint Problems
- Bowel Habit Change
- Breath Shortness
- Broken Bones or Bone Disease
- Cancer, Cyst, Growth, Tumor
- Cataracts
- Chest Pain/Pressure
- Chicken Pox/ Shingles
- Chills, Fever, Night Sweats
- Chronic Cough, Cold
- Convulsions/Seizures/Epilepsy
- Coughing or Vomiting Blood
- Depression
- Diabetes (Sugar)
- Dizziness
- Ear, Nose, Throat Trouble
- Epilepsy
- Eye Injury or Defect
- Fainting/Passing Out
- Falling
- Foot Trouble
- Gall Bladder Disease/Stones
- Glaucoma
- Gout
- Hay Fever
- Headaches
- Hearing Difficulties
- Heart Disease
- Hemorrhoids
- Hernia or Rupture
- High Blood Pressure
- HIV
- Hoarse Voice
- Indigestion (Frequent or Severe)
- Insomnia
- Kidney Stone/Blood in Urine

Yes No

- Knee Problems
- Liver Disease or Hepatitis
- Macular Degeneration
- Nervous Breakdown
- Neuropathy
- Numbness/Weakness
- Palpitation/Pounding Heart
- Pneumonia
- Rash or Hives
- Reaction from Medicine
- Rectal Disease
- Rheumatic Fever
- Scarlet Fever
- Shoulder, Arm, Hand Pain
- Skin Trouble
- Swelling - Ankle or Foot
- Swollen or Painful Joints
- Stroke
- Thyroid Problems
- Tuberculosis or Exposure to TB
- Ulcers
- Urinary Complaint
- Varicose Veins
- Venereal Disease
- Vision Difficulties
- Weight Gain
- Weight Loss
- Other _____
- _____
- _____

WOMEN

Number of Pregnancies _____

Date of Last Pap Smear _____

Date of Last Mammogram _____

MEN

Date of last PSA _____

Family History: Please check the boxes if your immediate family members have or had the following medical diseases:

Medical Disease	Specifics about Disease	Immediate Family Member (mother, father, sister(s), brother(s))
Cancer	What Type?	
Dementia (Memory Loss)	Cause of Dementia?	
Diabetes	Type I or Type II	
Heart Disease		
High Blood Pressure		
Lung Disease	Specific Lung Disease?	
Mental Illness	Specific Illness?	
Tuberculosis (TB)		
Other		

Mother: Cause of Death _____ Age at Death _____

Father: Cause of Death _____ Age at Death _____

YOUR NUTRITIONAL HEALTH

Read the statements below. Put a check in the Yes column for those statements that apply to you.

	YES	COMMENT	
1. I have an illness that made me change the kind or amount of food I eat.			2
2. I eat less than 2 meals a day.			3
3. I eat less than 4 servings of fruits and vegetables a day.			2
4. I have less than 2 cups of milk or yogurt a day.			2
5. I have 3 or more drinks of beer, liquor, or wine almost everyday.			2
6. I have tooth or mouth problems that make it hard for me to eat.			2
7. I don't always have enough money to buy the food I need.			4
8. I eat alone most of the time.			1
9. I take 3 or more medications a day.			1
10. Without trying, I have lost or gained 10 pounds in the last 6 months.			2
11. I am not always able to shop, cook and/or feed myself.			2

ACTIVITY	INDEPENDENT	NEEDS ASSISTANCE	UNABLE
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushing Teeth/Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting In/Out of Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bath/Showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any recent driving accidents? Yes No
 Are you currently driving? Yes No
 Any family/friends concerned about your driving? Yes No

CURRENT COMMUNITY SERVICES

- | | |
|---|--|
| <input type="checkbox"/> Meals on Wheels | <input type="checkbox"/> Veterans Administration |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Personal Care Aid/Home Health Aid |
| <input type="checkbox"/> Home Health Nurse | <input type="checkbox"/> Emergency Response System |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Home Medical Equipment |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Adult Day Care |
| <input type="checkbox"/> Senior Options _____ | <input type="checkbox"/> Passport _____ |
| <small>CASE MANAGER</small> | <input type="checkbox"/> Other _____ |
| | <small>CASE MANAGER</small> |

Have you experienced any of the following during the past year?

- | | | |
|--|--|--|
| <input type="checkbox"/> Major Illness | <input type="checkbox"/> Injury | <input type="checkbox"/> Close friend or relative die |
| <input type="checkbox"/> Moved | <input type="checkbox"/> Divorced or Separated | <input type="checkbox"/> Close friend or relative move |
| <input type="checkbox"/> Other _____ | | |

Is there anything you feel is important or should be discussed that has not been mentioned elsewhere on this form; or that you would like to explain in your own words?

Form completed by: (Name/Relationship)

How did you hear about us?

**Please return completed prescreen in the enclosed envelope or by fax 614-566-1916.
 If questions, please call (614) 566-5858.**

Thank You!