GERIATRICS & MEDICINE ASSOCIATES
HISTORY AND PHYSICAL

Name:_____ Date:_____

Address:_____ DOB: _____

Previous MD: _____ Address: _____ Last seen _____

Pharmacy_____ Address: _____ Phone _____

Other Physicians seen regularly:

MD:_____ Specialty_____ Phone: #_____ Last Seen: _____

MD:_____ Specialty_____ Phone: #_____ Last Seen: _____

MD:_____ Specialty_____ Phone: #_____ Last Seen: _____

MD:_____ Specialty_____ Phone: #_____ Last Seen: _____

SOCIAL HISTORY

Birth place: _____ Education: _____

Religion: _____ Employment: _____

Marital Status: _____# children/grand children: _____

Does someone else depend on you as a caregiver? _____

HABITS

Alcohol intake: _____ Smoking history: _____

Do you always use seatbelts? _____ Have you used street drugs? _____

Do you have smoke detectors? _____ Do you exercise regularly? _____

FAMILY HISTORY

	Medical History		Alive ☑	Deceased ☑
Parents - Mother			○	○
			○	○
Father			○	○
			○	○
Siblings			○	○
			○	○
			○	○
			○	○

Name: _____ DOB: _____

PRESENT HEALTH

Describe general health compared to others same age: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

General health over past 5 years: _____

_____

_____

Weight: Changes in past 6 months _____ past year _____

Describe typical day/hobbies: _____

_____

Have you ever been bothered by feeling down, depressed or hopeless? Yes No
Have you often been bothered by little interest or pleasure in doing things? Yes No

FUNCTIONAL STATUS:

Are you able to: (I=independently, A=with assistance, D=dependent on others for help)

Get dressed	I	A	D	Drive	I	A	D
Bathe	I	A	D	Use Phone	I	A	D
Use Toilet	I	A	D	Manage Money	I	A	D
Eat	I	A	D	Prepare Meals	I	A	D
Walk	I	A	D	Shop	I	A	D

Do you use: ☐ walker, ☐ cane, ☐ commode, ☐ raised toilet seat, ☐ hospital bed, ☐ wheelchair

Other assistive devices: _____

_____

IMMUNIZATION STATUS: (note most recent date)

Tetanus, diphtheria: _____ PPD: _____ Influenza: _____ Pnuemovax: _____

ADVANCED DIRECTIVES:

Do you have a health care proxy? Yes or No Name: _____

Do you have a Living Will? Yes or No

Name: _____ DOB: _____

HEALTH HISTORY

Medical Problems:

SURGERIES:

CURRENT MEDICATIONS: (include non-prescription drugs and vitamins)

Medications:	**Dose:**	**Frequency:**

ALLERGIES: (to drugs or other things: please include the kind of reaction)

_____

Name: _____ DOB: _____

REVIEW OF SYSTEMS: (please check symptoms you have had in the past six months)

General:	Skin:	Eyes:
Insomnia ☐	Lesions ☐	Vision changes ☐
Fatigue ☐	Wounds ☐	Pain ☐
Weight loss/gain ☐	Itch ☐	Cataracts ☐
Change in appetite ☐	Pigmentation changes ☐	Glaucoma ☐
Cold or heat intolerence ☐	Hair changes ☐	Double vision ☐
	Nail changes ☐	Photophobia ☐
	Abnormal bleeding	Infections ☐
	/bruising ☐	Glasses ☐
		Latest vision exam _____
Ears:	**Nose & Sinuses:**	**Mouth & Throat:**
Hearing changes ☐	Drainage ☐	Lesions/ulcers ☐
Drainage ☐	Bleeding ☐	Hoarseness ☐
Ringing ☐	Snoring ☐	Voice changes ☐
Vertigo ☐	Pain ☐	Difficulty swallowing or
Infections ☐	Post-nasal drip ☐	chewing ☐
Hearing Aid (R, L, both) ☐	Infections ☐	Altered taste ☐
		Sore Throat ☐
		Dentures (upper, lower,
		partials) ☐
Breasts:	**Respiratory:**	**Cardiovascular**
Lumps/Masses ☐	Cough ☐	Chest pain ☐
Pain ☐	Pneumonia ☐	Palpitations ☐
Nipple discharge/ ☐	Shortness of breath ☐	Shortness of breath
changes ☐	Wheezing ☐	with Exertion ☐
Latest Mammogram		Ankle Swelling ☐
date/results _____		Leg pain when walking ☐
		Stroke or TIA ☐
GI:	**GU:**	**Reproductive: Women**
Nausea or vomiting ☐	Pain or burning with	Vaginal discharge or ☐
Indigestion ☐	urination ☐	bleeding ☐
Heart burn ☐	Frequency ☐	Lesions ☐
Ulcers ☐	Hesitancy ☐	Infection ☐
Change in bowel habits ☐	Urgency ☐	Pain w/intercourse ☐
Diarrhea ☐	Incontinence ☐	Abonrmal Pap smears?
Constipation ☐	Bladder infections ☐	Yes or No
Hemorrhoid ☐	Do you get up at night to	Date of last Pap smear
	urinate? _____	_____
	How often? _____	Have you taken or do you take
		hormone therapy? Yes or No
Reproductive: Men	**Musculoskeletal:**	**Neuro/Psychosocial**
Penile discharge ☐	Joint pain ☐	Headache ☐
Lesions ☐	Stiffness ☐	Seizures ☐
Impotence ☐	Joint swelling ☐	Fainting ☐
Inadequate erections ☐	Cramping ☐	Coordination problem ☐
Prostrate problems ☐	Muscle weakness ☐	Head injury ☐
Cancer ☐	Gait problems ☐	Memory problem ☐
	Back pain ☐	Anxiety ☐
	Bone fractures ☐	Depression ☐
	Falls ☐	Insominia ☐
		Use of psychiatric meds ☐

Person Completing Form Signature: _____

Reviewed by: _____