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History Form

Name: _____ Today's Date: _____ Date of Birth: _____

Do you live alone or with someone? Alone Spouse Family Other:_____

Is your speech normal? Yes No

Please circle any family history:

Hypertension	Father	Mother	Siblings	Grandparents	Children
Heart Disease	Father	Mother	Siblings	Grandparents	Children
Stroke	Father	Mother	Siblings	Grandparents	Children
Diabetes	Father	Mother	Siblings	Grandparents	Children
High Cholesterol	Father	Mother	Siblings	Grandparents	Children
Depression	Father	Mother	Siblings	Grandparents	Children
Cancer	Father	Mother	Siblings	Grandparents	Children

Please circle any of your past medical history:

Hypertension	Diabetes	Heart Disease	Thyroid Disease
High Cholesterol	COPD	Depression	Stroke

Have you been admitted to this hospital this year? Yes No If yes, how many times? _____

Last flu shot: _____ Last pneumonia shot: _____

Last mammogram: _____ Last GYN exam: _____

Last colonoscopy: _____ Last bone density exam: _____

Last eye exam: _____

Please list your eye doctor or office: _____

Do you wear glasses or contacts daily? Yes No

Do you have an Advanced Directive or Living Will? Yes No

How often do you exercise? Yes No

How is your current physical health compared to last year? Same Better Worse

Do you or your family members have any concerns about your memory? Yes No

How is your current mental health compared to last year? Same Better Worse

Do you smoke? Yes No Former How many packs a day? _____

How many years have you smoked? _____

If former, what year did you quit? _____

Do you drink alcohol? Yes No

If yes, how many alcoholic drinks do you have a day? _____

Have you had more than 4– alcoholic drinks a day in the last year? Yes No

Do you use recreational drugs? Yes No

Are you at high risk for contracting HIV? Yes No

Functional/ADL Assessment:

Have you fallen in the last year? Yes No If yes, how many times? _____

Please circle if you use a: Walker Cane Wheelchair

Because of you health how would you rate daily activities? Please check the following:

	Independent	Need Assistance	Dependent
Feeding			
Dressing			
Going to Bathroom			
Walking			
Bathing			
Communicating			
Urinary Control			
Housework			
Transportation			
Finances			
Meal Preparation			
Take Medications			

Please Check the Following in the Depression Screening:

In the last two weeks, have you been bothered by any of the following problems?	Not at all	Several Days	More than Half (1/2) of the Days	Nearly Every Day
Loss of pleasure from activities	0	1	2	3
Difficulty falling asleep	0	1	2	3
Low self esteem	0	1	2	3
Decreased concentration	0	1	2	3
No desire to continue living	0	1	2	3
Fatigue	0	1	2	3
Feeling hopeless or worthless	0	1	2	3

Please list any specialists that you see:

_____

_____

_____