Geriatric and Medical Specialists of Michigan

Name_____ Date of Birth_____

Present Health Concerns: _____

MEDICATIONS: Prescription and non-prescription medications, vitamins, home remedies, birth control pills, herbs

Medication	Dose	Amount	Medication	Dose	Amount

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems

□ Asthma	□Dementia	□ Thyroid disease	□Alzheimer's
□Seizures	□Gout	□Glaucoma	□ Anemia
□Arthritis	□Pacemaker	□Alcohol problem	□High Blood Pressure
□Stroke	□ Tuberculosis	□Prostate problems	□Cancer: Type _____
□Aids/HIV	□Heart Disease	□Psychiatric care	□Emphysema
□Gallstones	□Diabetes	□Hernia	□Depression
□COPD	□Blood disorders	□Hepatitis	□ Osteoporosis
□Migraines	□Back trouble	□Anxiety	□ Incontinence:
□Psoriasis	□Liver problems	□ Kidney Problems	□Urinary
□Eczema	□Hearing Loss	□High cholesterol	□Fecal

□Other_____

_____

SURGICAL HISTORY: list any past surgeries or hospitalizations

Date	Reason/Procedure
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: check any allergies you have had and the reaction

____ No known drug allergies

____Penicillin _____

____Sulfa _____

____Aspirin _____

____ Codeine _____

____ Other _____

Other Providers: list all other medical providers that are currently treating you

Provider	Condition they are treating you for
_____	_____
_____	_____
_____	_____
_____	_____

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FAMILY HISTORY:

Please list any significant medical issues for immediate family members:
i.e: Cancer, Diabetes, Genetic Diseases, Heart problems, Mental retardation, Stroke, alcoholism, etc….
If family member is deceased please indicate cause of death and age at time of death.

Mother: _____

Cause of Death (if applicable)_____ Age of Death_____

Father: _____

Cause of Death (if applicable)_____ Age of Death_____

Brother: _____

Cause of Death(if applicable)_____ Age of Death_____

Sister: _____

Cause of Death(if applicable)_____ Age of Death_____

Daughter: _____

Son: _____

Other:_____

_____

_____

HEALTH MAINTENANCE SCREENING TESTS:

Please indicate if you have had any of the following tests/procedures

- Lipid Panel (cholesterol) Date_____
- Colonoscopy: Date_____ Place of Service _____
- Bone Density: Date_____ Did it show Osteoporosis? _____
- Women: Mammogram: Date_____ Place of service: _____
- Women: Pap Smear: Date _____ Abnormal? ☐ Yes ☐ No
- Men: PSA(Prostate) Date _____ Abnormal? ☐ Yes ☐ No

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SOCIAL HISTORY

Tobacco Use

Cigarettes:
Current Smoker: # packs/day_____ # of years____
Quit: Date _____
Never ☐
Other Tobacco: ____Pipe ____ Cigar ____Snuff ___Chew
Are you interested in quitting? ☐ No ☐ Yes

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes
drinks/week_____
Is alcohol use a concern for you or others?
☐ No ☐ Yes

Drug Use

Do you use any recreational drugs?
☐ No ☐ Yes, if yes what kind? _____

SOCIOECONOMICS:

Occupation: _____

Education completed: ☐ Grade School ☐ High school
☐ College ☐ Graduate School
Marital Status: ☐Single ☐ Married ☐ Seperated
☐ Divorced ☐ Widowed
Spouse/Partners name: _____
Number of children: _____
Who lives at home with you? _____

SAFETY:

Do you use seatbelts consistently? ☐ No ☐ Yes
Do you use a bike helmet regularly? ☐ No ☐ Yes
Is violence at home a concern? ☐ No ☐ Yes
Do you have a gun in your home? ☐ No ☐ Yes

WOMEN ONLY

pregnancies: _____ # deliveries: _____
abortions: _____ # Miscarriages: _____
Do you have any concerns about your periods?
☐ No ☐ Yes: _____
Do you have any concerns about menopause?
☐ No ☐ Yes: _____

SEXUALITY

Sexual Activity

Sexually Active: ☐ No ☐ Yes ☐ Not currently
Current sex partner(s) is/are: ____male ____female

Contraception and Protection

Are you interested in being screened for sexually
Transmitted diseases? ☐ No ☐ Yes
Birth Control method: _____
If sexually active, do you practice safe sex: ☐ No ☐ Yes

Have you ever had any sexually transmitted diseases
(STD'S)? ☐ No ☐ Yes
If yes, please explain:
_____date_____

IMMUNIZATIONS

Please check any immunization you have had and the approximate year

Immunization	Year
____ Tetanus	_____
____ Pneumovax	_____
____ Hepatitis B	_____
____ influenza	_____
____ Zostavax	_____

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Notice of Acknowledgement
Patient Rights, Ethics and Advance Directive

An Advance Directive is a legal document allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if he or she should lose decision-making capacity. Advance Directives are the following written instruments: the Living Will, the assignment of a Healthcare Surrogate, the assignment of a Healthcare Power or Attorney. The instrument may be revoked at any time. Should it be revoked, a notation of date and time must be made to the patient's medical chart.

1. Do you have an Advance Directive? ☐ Yes ☐ No
   If yes, what type?
   A. Living Will ☐ Yes ☐ No
   B. Assignment of a Healthcare Power of Attorney ☐ Yes ☐ No
   C. Assignment of a Healthcare Surrogate ☐ Yes ☐ No
      Power of Attorney:_____
      Surrogate's name:_____
      Surrogate's address:_____
      Surrogate's telephone #:_____

2. Would you like additional information on Advance Directives?

Geriatric and Medical Specialists has provided me with written information regarding patients rights and responsibilities, ethics, policies governing the implementation of Advance Directives, and information on executing Advance Directives.

I understand that it is my responsibility to provide a copy of my Advance Directive designation to Geriatric and Medical Specialists of Michigan.

_____ _____/_____/_____
Signature of Patient or Representative Date

_____ _____/_____/_____
Signature of Witness Date