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: (Must be completed in it's entirety)

Please list any significant medical issues for immediate family members:

Mother: _____ Living or Deceased
If Deceased-Cause of Death _____ Age of Death_____
Health Issues: (Circle all that apply) Cancer, Diabetes, Genetic Diseases, Heart problems, Mental illness, Stroke, alcoholism, Hypertension, COPD, Alzheimer/Dementia, Kidney Disease, High Cholesterol

Father: _____ Living or Deceased
If Deceased-Cause of Death _____ Age of Death_____
Health Issues: (Circle all that apply) Cancer, Diabetes, Genetic Diseases, Heart problems, Mental illness, Stroke, alcoholism, Hypertension, COPD, Alzheimer/Dementia, Kidney Disease, High Cholesterol

Siblings(1): _____ Living or Deceased
If Deceased-Cause of Death _____ Age of Death_____
Health Issues: (Circle all that apply) Cancer, Diabetes, Genetic Diseases, Heart problems, Mental illness, Stroke, alcoholism, Hypertension, COPD, Alzheimer/Dementia, Kidney Disease, High Cholesterol

Siblings(2): _____ Living or Deceased
If Deceased-Cause of Death _____ Age of Death_____
Health Issues: (Circle all that apply) Cancer, Diabetes, Genetic Diseases, Heart problems, Mental illness, Stroke, alcoholism, Hypertension, COPD, Alzheimer/Dementia, Kidney Disease, High Cholesterol

Siblings(3): _____ Living or Deceased
If Deceased-Cause of Death _____ Age of Death_____
Health Issues: (Circle all that apply) Cancer, Diabetes, Genetic Diseases, Heart problems, Mental illness, Stroke, alcoholism, Hypertension, COPD, Alzheimer/Dementia, Kidney Disease, High Cholesterol

(List any additional siblings on back)

Natural Child (1): _____ Living or Deceased
If Deceased-Cause of Death _____ Age of Death_____
Health Issues: (Circle all that apply) Cancer, Diabetes, Genetic Diseases, Heart problems, Mental illness, Stroke, alcoholism, Hypertension, COPD, Alzheimer/Dementia, Kidney Disease, High Cholesterol

_____

Natural Child (2): _____ Living or Deceased
If Deceased-Cause of Death _____ Age of Death_____
Health Issues: (Circle all that apply) Cancer, Diabetes, Genetic Diseases, Heart problems, Mental illness, Stroke, alcoholism, Hypertension, COPD, Alzheimer/Dementia, Kidney Disease, High Cholesterol

_____

Natural Child (3): _____ Living or Deceased
If Deceased-Cause of Death _____ Age of Death_____
Health Issues: (Circle all that apply) Cancer, Diabetes, Genetic Diseases, Heart problems, Mental illness, Stroke, alcoholism, Hypertension, COPD, Alzheimer/Dementia, Kidney Disease, High Cholesterol

(List any additional children on back)

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SOCIAL HISTORY

Name_____ Date of Birth_____

Tobacco Use
Never □
Cigarettes:
Current Smoker: # packs/day_____ # of years____
Quit: Date _____
Other Tobacco:___Pipe ___ Cigar ___Snuff ___Chew
Are you interested in quitting? □ No □ Yes

Drug Use:
Do you use any recreational drugs?
□ No □ Yes, if yes what kind? _____

Alcohol Use
Do you drink alcohol? □ No □ Yes
If yes, # drinks/week _____

SOCIOECONOMICS:
Education completed: □ Grade School □ High school
□ College □ Graduate School

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_____

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 monthly cycle?
If Yes explain: _____
Do you have any concerns about menopause?
If Yes explain: _____

IMMUNIZATIONS:	**Year:**
_____ Tetanus	_____
_____ Pneumovax	_____
_____ Hepatitis B	_____
_____ Influenza	_____
_____ Zostavax	_____

HEALTH MAINTENANCE SCREENING TESTS:
Please indicate if you have had any of the following
tests/procedures ***within the last year***
Lipid Panel (cholesterol) Date_____
Last 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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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