Geriatric Health Questionnaire

Family Care Center

University of Iowa Health Care requests this information for the purpose of providing patient care. No persons outside the University are provided this information without your consent. If you fail to provide this information, patient care may be impaired. If you have questions, please ask for help.

·File most recent on Bottom in Section 1·

DATE

HOSP. #

NAME

BIRTH DATE

ADDRESS

IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. # NAME AND LOCATION

INSTRUCTIONS: PLEASE CIRCLE ANSWERS.

1. General Health: In general, would you say your health is:
Excellent / Very Good / Good / Fair / Poor

How much bodily pain have you had during the past 4 weeks?
None / Very Mild / Mild / Moderate / Severe / Very Severe

2. Activities of Daily Living: Are you independent (I) (can do by myself), require assistance (A) (need help from another person), or dependent (D) (cannot do at all) with each of the following tasks?

Walking	I	A	D	Using Telephone	I	A	D
Dressing	I	A	D	Shopping	I	A	D
Bathing	I	A	D	Preparing Meals	I	A	D
Eating	I	A	D	Housework	I	A	D
Toileting	I	A	D	Taking Medications	I	A	D
Driving	I	A	D	Managing Finances	I	A	D

3. Geriatric Review of Systems:

a. Do you have difficulty driving, watching TV or reading because of poor eyesight? ..... Yes / No

b. Can you hear normal conversational voice? ..... Yes / No
Do you use hearing aides? ..... Yes / No

c. Do you have problems with your memory? ..... Yes / No

d. Do you often feel sad or depressed? ..... Yes / No

e. Have you unintentionally lost weight in the last 6 months? ..... Yes / No

f. Do you have trouble with control of your bladder? ..... Yes / No
Do you have trouble with control of your bowels? ..... Yes / No

g. How many falls have you had in the past year? _____

(cont'd on back)

Patient Name _____

Hospital # _____

h. Do you drink alcohol? ..... Yes / No

If yes, how many drinks per week? _____

4. Do you live with anyone? ..... Yes / No

If yes, who? Spouse / Child / Other / Relative / Friend

Who would help you in an emergency? _____

Who would help you with health care decisions if you were not able to communicate your wishes? _____

5. How many medicines do you take, including prescribed, over the counter and vitamins? _____

What is your system for taking your medications?

Pill box / Family help / List or chart / None

6. Are you sexually active? ..... Yes / No

7. Has anyone intentionally tried to harm you? ..... Yes / No

8. Have you had a shot to prevent pneumonia? ..... Yes / No

9. Please draw the face of a clock with all the numbers and the hands set to indicate 10 minutes after 11 o'clock.

Memory: 3 item recall after 1 minute (pen, dog, watch) # recalled _____

Patient Signature: _____ **Date**: _____

Reviewing physician: _____ **Date:** _____