STARR
PRIMARY CARE
GERIATRICS

Rebecca Starr, MD

264 Elm Street, Northampton, Ma 01060

NEW GERIATRIC EVALUATION PATIENT INFORMATION FORM

General Information:

Name: _____ Date of Birth: _____

Preferred Name: _____ Language Spoken: _____

What gender were you assigned at birth? ○ Male ○ Female

What is your current gender? ○ Male ○ Female ○ Non-Binary/Genderqueer

Primary Care Provider: _____

Office Phone Number: _____ (if known)

Pharmacy Name and Location: _____

Who referred you to Dr. Starr? ○ Self-referred ○ Referred by:_____

Person who should be contacted for follow up appointments:

Name: _____

Address: _____

Phone #: _____

What are your goals for this visit?

_____

_____

_____

_____

_____

Any problems or concerns that you would like the doctor to know about before your visit?

_____

_____

_____

_____

Have you had any recent ER visits or Hospitalizations? If yes, please describe:

_____

_____

_____

_____

Do you need or have help with the following (check appropriate column)?

	Perform independently	Need Some Assistance	Need Total Assistance
☐ Bathing			
☐ Dressing			
☐ Toileting			
☐ Moving in and out of bed or chair			
☐ Feeding – gets food from plate into mouth			
☐ Driving			
☐ Paying bills and managing finances			
☐ Shopping			
☐ Preparing food & housekeeping			
☐ Taking Medications			

Do you employ someone to help in your home? ○ Yes ○ No If yes, # hours _____

Who provides the care? _____

What tasks do they help with? _____

Do you provide care for a family member? ○ Yes ○ No If you, who? _____

General Information about you

Do you use a: ○ Cane ○ Walker ○ Wheelchair

Have you had any falls in the past year? ○ Yes ○ No

If yes, how many? _____ When? _____ Injuries? _____

Are you afraid of falling? ○ Yes ○ No

How would you describe your sleep? ○ Good ○ Fair ○ Poor

Do you snore? ○ Yes ○ No ○ Don't know

Have you ever been tested for sleep apnea? ○ Yes ○ No ○ Don't know

How is your appetite? ○ Good ○ Fair ○ Poor

Has food intake declined over the past 3 months? ○ Yes ○ No ○ Don't know

Have you lost weight over the last year? ○ Yes ○ No ○ Don't know

Have you gained weight over the last year? ○ Yes ○ No ○ Don't know

Would you like assistance with meals and food? ○ Yes ○ No

Do you have any concerns about finances? ○ Yes ○ No

Comments:

_____

_____

_____

Health Maintenance

How do you think your health compares to most people of your age? ○ Good ○ Fair ○ Poor

Do you feel sad or depressed most days? ○ Yes ○ No

Do you feel worried or anxious? ○ Yes ○ No

Do you feel you have more memory problems than most people your age?	○ Yes	○ No
Are you or others concerned about your memory?	○ Yes	○ No
Do you feel safe at home?	○ Yes	○ No
Have you had a hearing test within the last two years?	○ Yes	○ No
Have you had an eye exam within the past year?	○ Yes	○ No
Have you had any dental exam within the past year?	○ Yes	○ No

Health Maintenance *(continued)*

Do you feel like you have decreased the amount of time you spend time with family and friends in the last year?	○ Yes	○ No

Fitness Level

Do you feel tired during the day?	○ Yes	○ No
Can you walk up a flight of stairs?	○ Yes	○ No
Can you walk around the block?	○ Yes	○ No
Do you currently participate in any regular activity to improve or maintain your physical fitness?	○ Yes	○ No

Past Medical History

Which medical conditions do you have or have had in the past? (*check all that apply*)

EYE AND EAR PROBLEMS
- ○ Cataracts
- ○ Glaucoma
- ○ Macular degeneration
- ○ Hearing loss / hearing aid

KIDNEY & URINARY TRACT PROBLEMS
- ○ Kidney disease
- ○ Prostate disease
- ○ Frequent urinary infections
- ○ Urinary incontinence

LUNG PROBLEMS
- ○ Asthma
- ○ COPD
- ○ Bronchitis

NERVOUS SYSTEM PROBLEMS
- ○ Stroke. When?
- ○ Dementia / Alzheimer's Disease
- ○ Parkinson's Disease

HEART PROBLEMS
- ○ Heart attack. When?
- ○ Heart failure
- ○ High blood pressure
- ○ Irregular heart beats / arrhythmias

BONE & JOINT PROBLEMS
- ○ Arthritis
- ○ Osteoporosis
- ○ Gout

Fractured ○ hip, ○ wrist, ○ spine ○ other
When:_____

GASTROINTESTINAL PROBLEMS
- ○ Ulcers
- ○ Heartburn
- ○ Diverticulitis
- ○ Liver disease / cirrhosis
- ○ Hepatitis
- ○ Polyps
- ○ Gallbladder disease

OTHER HEALTH PROBLEMS
- ○ Anemia
- ○ Hernia
- ○ Thrombosis (blood clots)
- ○ Cancer. Where?
- ○ Depression
- ○ Sexual problems
- ○ Other, specify:

GLAND PROBLEMS
- ○ Diabetes
- ○ Thyroid Disease

List surgeries (operations). Use an additional page, if needed.

DATE	SURGERY (OPERATION)

List Other Hospitalizations. Use an additional page, if needed.

DATE	REASON

List all medicines that you use (Prescriptions, Non-Prescriptions, Natural Products) OR you can bring in your own list from home instead.
REMEMBER to bring all your medications to your appointment

Name of medication	What strength?	How do you use it? (How many? How many times a day?)
Example: Tylenol	*500 mg.*	*1 pill 3 times a day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Do you have any drug allergies? If yes, specify below.

NAME OF DRUG	REACTION

Social History

Where were you born / raised? _____

What is your level of education? _____

Which of the following best describes your residence? (check one)

- ◒ Single-family house
- ○ Condo or apartment
- ○ Live with other in their home, condo or apartment
- ○ Senior resident / Independent living
- ○ Assisted living facility
- ○ Other, specify:

Sexual Orientation (*check one*)

□ Heterosexual/Straight □ Gay/Lesbian/Homosexual □ Bisexual/Queer □ Other _____

Are you currently (*check one*)

○ Married ○ Divorced / Separated ○ Widowed ○ Single / Never married
○ Living with significant other. Who? _____

Employment history (*check one*)

○ Retired / Not working ○ Working part-time ○ Working full-time ○ Volunteering

What was your primary occupation?

_____

How many children do you have? _____

If you have children, are you in regular contact with your children? ○ Yes ○ No ○ N/A

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

○ Daily ○ Almost daily (4 to 6 times a week) ○ 1 to 3 times a week
○ Less than 1 time a week ○ Never ○ Used to drink but quit

If you drink alcohol, has anyone ever been concerned about your drinking? ○ Yes ○ No

Are you concerned about your alcohol intake? ○ Yes ○ No

Have you ever smoked cigarettes? ○ Yes ○ No

If currently smoking: How much do you smoke? _____packs per day

If no longer smoking: How much did you smoke? _____packs per day

For how many years did you smoke? _____

How long ago did you quit? _____

Did you ever use drugs such cannabis, cocaine or IV drugs? ○ Yes ○ No

If yes, what? _____

Do you still use drugs such as cannabis, cocaine or IV drugs? ○ Yes ○ No

REVIEW OF SYSTEMS *Check all that apply*:

Constitutional	○ Non	○ fever ○ tiredness/fatigue
Eyes	○ None	○ glasses ○ blurred vision ○ double vision
Ears/Nose/Throat	○ None	○ sinus infection ◉ deafness ○ ear ringing ○ difficulty swallowing
Heart	○ None	○ chest pain ○ irregular heartbeat
Lungs	○ None	○ shortness of breath ○ wheezing ○ cough
Abdomen	○ None	○ diarrhea ○ constipation ○ pain ○ bowel incontinence
Urinary	○ None	○ incontinence ○ difficulty voiding ○ infections ○ blood in urine
Musculoskeletal	○ None	○ pain ○ arthritis
Skin	○ None	○ rash ○ skin ulcers ○ sores ○ lumps/masses
Neurologic	○ None	○ tingling ○ balance problems ○ dizziness
Behavioral	○ None	○ depression ○ anxiety ○ hallucinations ○ mental illness
Blood/lymphatics	○ None	○ blood clots ○ easy bruising ○ leg swelling

Other:_____

Advanced Care Planning:

Do you have a Health Care Proxy? ○ Yes Please bring a copy ○ No
Do you have a completed MOLST form? ○ Yes Please bring a copy ○ No
Who would you like to be involved in your care?

- ○ Primary care physician
- ○ Family: _____
- ○ Friends: _____

If you are filling out this form for yourself: What matters most to you at this point in your life?

If you are filling out this form for someone that you care for: Based on your knowledge of the person you care for, what do you think matters most to them right now? _____

As a caregiver, what matters most to you right now? _____
_____

Any other information that you would like to share: _____

Completed by: _____ Date: _____ Time:_____

Print name: _____ Relationship if not patient: _____