EvergreenHealth
GERIATRIC CARE

Geriatric Care Consultation Questionnaire

evergreenhealth.com

Why were you referred for a consult?

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What are you hoping to accomplish at your visit today?

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Review of Systems:

To be sure that we have covered everything, during the last three months, have you had any of the following symptoms or problems? (Check all that apply)

Constitutional:
❒ Fatigue
❒ Poor appetite
❒ Weight loss
❒ Weight gain

Kidney & Urinary Tract Problems
❒ Painful urination (burning)
❒ Frequent infections
❒ Urine leakage (incontinence)

Eye problems
❒ Impaired vision
❒ Cataracts

ENT
❒ Decreased hearing
❒ Snoring

Hematology Problems
❒ Bruising tendency
❒ Swollen lymph nodes and glands

Bone and Joint Problems
❒ Back pain
❒ Joint pains_____________
❒ Unstable gait/balance

Lung Problems
❒ Shortness of breath
❒ Cough
❒ Sputum production

Heart Problems
❒ Chest pain or tightness
❒ Palpitations
❒ Leg swelling

Digestion Problems
❒ Nausea/vomiting
❒ Diarrhea
❒ Constipation
❒ Swallowing problems

Brain and Nervous System Problems
❒ Confusion
❒ Numbness and tingling
❒ Dizziness
❒ Headache
❒ Memory problems or difficulty thinking
❒ Tremor or shaking
❒ Vivid dreams
❒ Restless legs

Mental Health Problems
❒ Anxiety
❒ Depression
❒ Behavior change
❒ Sleeping problems
❒ Hallucinations
❒ Paranoia

Other:

Anything not checked is negative

Family History: **unknown ___ adopted ____ unable to obtain ___(Mark “x” if present)**

Neurologic	Mother	Father	Sister	Brother	Other/comment
Dementia	❒	❒	❒	❒	❒_______________
Alzheimer’s	❒	❒	❒	❒	❒_______________
Parkinson	❒	❒	❒	❒	❒_______________

Cardiovascular	Mother	Father	Sister	Brother	Other/comment
Heart Disease	❒	❒	❒	❒	❒_______________
High Cholesterol	❒	❒	❒	❒	❒_______________
Hypertension	❒	❒	❒	❒	❒_______________

Respiratory	Mother	Father	Sister	Brother	Other/comment
Sleep Apnea	❒	❒	❒	❒	❒_______________
Restless legs	❒	❒	❒	❒	❒_______________

Musculoskeletal	Mother	Father	Sister	Brother	Other/comment
Osteoporosis	❒	❒	❒	❒	❒_______________

Mental Health	Mother	Father	Sister	Brother	Other/comment
Alcoholism	❒	❒	❒	❒	❒_______________
Bipolar Disease	❒	❒	❒	❒	❒_______________
Depression	❒	❒	❒	❒	❒_______________

Endocrinology	Mother	Father	Sister	Brother	Other/comment
Diabetes	❒	❒	❒	❒	❒_______________
Thyroid problems	❒	❒	❒	❒	❒_______________

Employment:

What type of work did you do? ______________________________

What is the highest grade level you completed in school? ___________________________

Exercise:

Do you exercise? ❒ Yes ❒ No

How often do you exercise? __________________________ What type of exercise? ____________

Home Environment:

Where do you live? ____

Do you have family or friends available to assist you? ________________________________

Do you live in a retirement home or assisted living? _________________________________

Do you have any caregivers (family or paid)? _______________________________________

You use any assistive devices (walker, wheelchair, cane)? ___________________________

Medications:

Do you need assistance taking or setting up your medications? ❒ Yes ❒ No

Habits:

Do **you** drink alcohol? ❒ Yes, currently ❒ Yes, in the past ❒ No
How often do you drink alcohol? ________________________
Do you smoke? ❒ Yes ❒ Yes, in the past ❒ No
Do you use marijuana? ______________________________________

Future Planning:

Do you have an advanced directive? ❒ Yes ❒ No Living will? ❒ Yes ❒ No
Do you have a durable power of attorney for health care matters? ❒ Yes ❒ No
If yes, who is your power of attorney (DPOA)? ________________________________
Do you have a POLST (a bright lime green form)? ❒ Yes ❒ No

List any hospitalizations or falls you have had in the past year:

Date of hospitalization	Reason for hospitalization

Dates of falls	Circumstances of falls

We want to know if you need help with any of the following tasks and who helps you. Please fill out information for each task.

Activities	Yes Needs help	No Don't need help	If yes, Who helps you
Feeding yourself	❒ YES	❒ NO	Who helps you?____________________
Getting from your bed to a chair	❒ YES	❒ NO	Who helps you?____________________
Getting to the toilet	❒ YES	❒ NO	Who helps you?____________________
Getting dressed	❒ YES	❒ NO	Who helps you?____________________
Bathing	❒ YES	❒ NO	Who helps you?____________________
Using the telephone	❒ YES	❒ NO	Who helps you?____________________
Taking your medicines	❒ YES	❒ NO	Who helps you?____________________
Preparing your meals	❒ YES	❒ NO	Who helps you?____________________
Managing your money	❒ YES	❒ NO	Who helps you?____________________
Doing laundry	❒ YES	❒ NO	Who helps you?____________________
Shopping for groceries	❒ YES	❒ NO	Who helps you?____________________
Home repairs	❒ YES	❒ NO	Who helps you?____________________
Climbing a flight of stairs	❒ YES	❒ NO	Who helps you?____________________
Driving/transportation	❒ YES	❒ NO	Who helps you?____________________