NEW GERIATRICS PATIENT COMPREHENSIVE QUESTIONNAIRE

(Complete all pages front and back)

Patient's Name				Gender
Date of Birth	Marital Status	Religion	Veteran? ☐ Yes ☐ No	Race/Ethnicity (Please see page 2)
Patient's Address				Patient's Phone
Patient's Email				Patient's Cell Phone
Patient's Preferred Language				Interpreter Needed? ☐ **Yes** ☐ **No**

Referring Source	Referring Physician	Prior Primary Care Physician (PCP)

Emergency Contact Name	Relationship to Patient	EMC Phone	EMC Address

Primary Insurance Plan Name	Group Name	Group Number
Policy Number	Health Plan Type	

Do you have a smart device (cell phone or tablet) or a computer with a camera? ☐ **Yes** ☐ **No**
If yes, do you have the ability to do video visits? ☐ **Yes** ☐ **No**

Demographic Validation

I have reviewed the demographic and insurance information provided above. The above information is accurate and correct.

Patient Signature:

X_____

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(Complete all pages front and back)

Why are we asking about your race, ethnicity, language, and pronouns?

We want to make sure that every patient receives personalized health care and is able to live their healthiest life. We ask all of our patients about their race and ethnicity so that we can address any differences in health outcomes across the communities we serve. We also ask everyone about language and pronouns so that we are providing care in a respectful way. Everyone's responses are private.

DO YOU IDENTIFY WITH SPANISH / HISPANIC / LATINO ETHNICITY? (Select or write in up to two)

- ☐ I am Spanish / Hispanic / Latino
- ☐ I am not Spanish / Hispanic / Latino
- ☐ I decline to respond

If you identify as Spanish / Hispanic / Latino, please let us know your specific background. For example: Dominican, Latin American, Mexican, Puerto Rican

_____

PLEASE TELL US WITH WHICH RACE(S) YOU IDENTIFY: (select or write in up to two)

"Race" is one way our society groups people together. Categories of race have been made up over time. These categories are often based on things we can see, like a person's skin color. Our race is a combination of the races of our parents.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ White
- ☐ I decline to respond

Please let us know your specific background. For example: Asian-Indian, Bangladeshi, Chinese, Filipino, Haitian, Pakistani

_____

WHAT ARE YOUR PRONOUNS AND PREFERRED LANGUAGE?

"Pronouns" are how we want to be referred to in addition to our name. Common pronouns include "He/Him," "She/Her" and "They/Them" Pronouns (optional – choose one)

- ☐ He/Him
- ☐ She/Her
- ☐ They/Them
- ☐ Other

"Language" is what we speak, read, and write. Some people may know more than one language, but are more comfortable with one language versus another.

Please let us know your preferred language:

_____

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(Complete all pages front and back)

CURRENT MEDICAL PROBLEMS

What brings you in today? Establish Primary Care ☐ Consultation ☐ Other (please specify) ☐

Where have you received medical care prior to this visit?

Please list the name and phone number of your specialty provider(s) at Mount Sinai:

Please list the name and phone number of your non-Mount Sinai specialty provider(s):

CURRENT MEDICATIONS

Please list your medications, with the dose and frequency. Please include over the counter preparations, including any vitamins, herbs, or supplements.

Name	Dose	Frequency	Reason for Medication

NEW GERIATRICS PATIENT COMPREHENSIVE QUESTIONNAIRE

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ALLERGIES

Do you have any allergies to medication? If yes, please list and note the reaction. ☐ Yes ☐ No

Medication	Reaction

Do you have allergies to anything else (foods or environmental exposures)? If yes, please list and note the reaction. ☐ Yes ☐ No

Food/Environment	Reaction

ACTIVE MEDICAL HISTORY

Medical History	How Long?	Doctor Treating

PAST MEDICAL HISTORY

Medical History	How Long?	Doctor Treating

SURGERY / PROCEDURES

Procedure	Date	Doctor	Hospital

NEW GERIATRICS PATIENT COMPREHENSIVE QUESTIONNAIRE

(Complete all pages front and back)

Have you been hospitalized in the past year? ☐ Yes ☐ No

If yes, please list date and location of hospitalization:

FAMILY MEMBER'S HEALTH

If deceased, indicate age and cause of death

List of any health problems	Relationship(s) and age(s) of onset	Comments

HOME ACCESSIBILITY

Do you use any of the following: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Shower chair ☐ Grab bars ☐ Raised toilet seat ☐ Commode ☐ Hospital bed

Do you receive any services at home, such as home health aide, home attendant, or visiting nurse?

☐ Yes ☐ No

If Yes, how many hours of help do you have each day / week?

ADVANCE DIRECTIVES

Do you have a healthcare proxy?	☐ Yes ☐ No	If yes, please provide a copy of the form at your visit.
Do you have a MOLST, Living Will, or other advance directive?	☐ Yes ☐ No	If yes, please provide a copy at your visit.

SOCIAL HISTORY: Please provide a brief answer to the following questions:

What is or was your occupation? _____

What type of building do you reside in? ☐ Elevator ☐ Walkup If walkup, floor #: ____

Do you have children? ☐ Yes ☐ No - If yes, please provide their names:

NEW GERIATRICS PATIENT COMPREHENSIVE QUESTIONNAIRE

(Complete all pages front and back)

Transportation needs: in the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

☐ Yes ☐ No ☐ Decline to answer

Housing stability: what is your/your family's housing situation today?

Private residence ☐ Skilled nursing facility ☐ Assisted living facility

Group home ☐ Single room occupancy ☐ Homeless / Unhoused ☐ Decline to answer

If selected homeless / unhoused:

☐ Shelter ☐ Unsheltered (e.g., staying with friend) ☐ Unspecified

Food security: in the past 12 months, has the food you bought just not lasted and you didn't have money to get more?

☐ Never true ☐ Sometimes true ☐ Often true ☐ Decline to answer

Utilities: in the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Yes ☐ No ☐ Already shut off ☐ Decline to answer

Do you live alone or with someone? ☐ Alone ☐ With someone: _____

Has anyone in your family or home ever physically or verbally hurt you? ☐ Yes ☐ No

Do you have any religious or cultural beliefs that your provider should know about before beginning medical treatment? ☐ Yes ☐ No If yes, please explain:

_____

Do you exercise regularly? Type? Frequency? _____

Do you have any dietary restrictions? ☐ Yes ☐ No - If yes, please list:

_____

SEXUAL HISTORY: Sexually active? ☐ Yes ☐ No

HABITS

Tobacco:

☐ Yes - How many packs per day? ____

☐ No, never

☐ No, quit – Quit date: _____

How many years did you smoke? _____

How many packs per day? _____

Alcohol:

☐ Yes - Number of drinks per week _____

Type of alcohol: _____

☐ No

Other drugs:

☐ No

☐ Yes

Type: _____

Date last used: _____

NEW GERIATRICS PATIENT COMPREHENSIVE QUESTIONNAIRE

(Complete all pages front and back)

FUNCTIONAL STATUS: Please check the appropriate box for the following activities.

How well are you able to perform the following activities of daily living in your home?

Place a check mark √ in the appropriate box next to the question.

	Independent 3	**Need assistance** 2	**Dependent** 1
Do you need assistance with getting around or walking (mobility)?	☐	☐	☐
Do you need assistance with eating or drinking?	☐	☐	☐
Do you need assistance with dressing yourself?	☐	☐	☐
Do you need assistance with grooming?	☐	☐	☐
Do you need assistance with bathing?	☐	☐	☐
Do you need assistance with using the toilet (toileting)?	☐	☐	☐

Do you ever lose control of urine or bowel movements?	**Never** 4 ☐	**< 1 x/week** 3 ☐	**1 or 2x/week** 2 ☐	**3 or more x/week** (1) ☐

ACTIVITY	**Independent** 3	**Partially able** 2	**Unable** 1
Telephone use	☐	☐	☐
Shopping	☐	☐	☐
Food preparation	☐	☐	☐
Housekeeping	☐	☐	☐
House Repairs	☐	☐	☐
Laundry	☐	☐	☐
Transportation	☐	☐	☐
Taking Medicine	☐	☐	☐
Financial Management	☐	☐	☐

NEW GERIATRICS PATIENT COMPREHENSIVE QUESTIONNAIRE

(Complete all pages front and back)

SYMPTOM REVIEW:

Have you experienced any of the following **in the past three months?** Check all that apply.

- ☐ WEIGHT CHANGES
- ☐ DEPRESSION
- ☐ MEMORY LOSS
- ☐ FALLS

- ☐ HEARING LOSS
- ☐ VISUAL LOSS
- ☐ SLEEP DISTURBANCE
- ☐ FEVER/CHILLS

- ☐ VISUAL BLURRING / DOUBLE VISION
- ☐ EYE PAIN
- ☐ BLIND SPOT
- ☐ ITCHY EYES

- ☐ RINGING IN THE EARS
- ☐ ROOM SPINNING
- ☐ BLOODY NOSES
- ☐ DEVIATED SEPTUM
- ☐ FREQUENT RESPIRATORY INFECTIONS
- ☐ SINUS TROUBLE
- ☐ PERSISTENT SORE THROAT
- ☐ BLEEDING GUMS
- ☐ DENTAL PROBLEMS
- ☐ HOARSE VOICE
- ☐ HEADACHE
- ☐ EAR PAIN
- ☐ JAW PAIN

- ☐ COUGH
- ☐ SHORTNESS OF BREATH
- ☐ PRODUCTIVE COUGH
- ☐ COUGHING UP BLOOD
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH WITH MOVEMENT

- ☐ PAIN WHEN WALKING
- ☐ BACK PAIN
- ☐ BONE PAIN
- ☐ MUSCLE PAIN
- ☐ MUSCLE WEAKNESS
- ☐ FATIGUE
- ☐ JOINT PAIN OR SWELLING
- ☐ ENLARGED VEINS

OTHER: _____

- ☐ URINATING MORE THAN USUAL
- ☐ LEAKAGE OF URINE
- ☐ PAINFUL URINATION
- ☐ URINATION URGENCY
- ☐ ERECTILE DYSFUNCTION

- ☐ VAGINAL ITCHING/DRYNESS
- ☐ SPOTTING/DISCHARGE
- ☐ PAINFUL INTERCOURSE
- ☐ BREAST MASS
- ☐ NIPPLE DISCHARGE

- ☐ PALPITATIONS
- ☐ RACING HEART
- ☐ CHEST PAIN
- ☐ DIFFICULTY/PAINFUL SWALLOWING
- ☐ ABDOMINAL PAIN
- ☐ EXCESSIVE GAS/BLOATING
- ☐ BLOOD IN STOOLS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ NAUSEA
- ☐ VOMITING
- ☐ ACID REFLUX/HEARTBURN

- ☐ SKIN RASH
- ☐ ITCHING

- ☐ FAINTING
- ☐ SEIZURES
- ☐ NUMBNESS/TINGLING OF HANDS/FEET
- ☐ TREMOR
- ☐ DIZZINESS
- ☐ LIGHTHEADEDNESS
- ☐ ANXIETY
- ☐ HALLUCINATIONS
- ☐ HOT FLASHES
- ☐ HEAT/COLD INTOLERANCE
- ☐ EXCESSIVE THIRST
- ☐ BLEEDING
- ☐ BRUISING
- ☐ NIGHT SWEATS
- ☐ SWOLLEN NODES
- ☐ HIVES
- ☐ ALLERGIES

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(Complete all pages front and back)

HEALTH MAINTENANCE & IMMUNIZATIONS

	Completed? (Yes/No)	Date	Abnormalities?
Cancer Screenings			
Mammogram			
Pap Smear			
Colonoscopy			
Stool Test			
General Health Screenings			
Bone Density (DEXA)			
Eye Exam			
Hearing Test			
Dental Exam			
Podiatry (Foot Exam)			
Vaccines			**List type, if known**
Flu			
Pneumonia			
COVID			
RSV			
Tetanus			
Shingles			