# MOUNT SINAI DOCTORS SENIOR HEALTH –
# COMPREHENSIVE QUESTIONNAIRE (Complete all pages front and back)

| Patient's Name | | | Gender | Race/Ethnicity **(Please see page 3)** | |
|---|---|---|---|---|---|
| Social Security Number | Age | Date of Birth | Marital Status | Religion | Veteran (Y/N) |
| Patient's Address | | | Patient's Phone | | |
| Patient's E-Mail | | | Patient's Cell Phone | | |
| Patient's Preferred Language | | | Interpreter Needed? **(YES / NO)** | | |

| Employment Status | Employer Name | Employer Phone |
|---|---|---|
| Employer Address | | Patient Work Phone |

| Referring Source | Referring Physician | Prior Primary Care Physician (PCP) |
|---|---|---|
| Referring Source Phone Number | Referring Physician Number | Referring Physician Phone Number |

| Next of Kin | Relationship to Patient | NOK Phone | NOK Address |
|---|---|---|---|
| Emergency Contact | Relationship to Patient | EMC Phone | EMC Address |

| **Primary Insurance Plan Name** | | Group Name | Group Number |
|---|---|---|---|
| Policy Number | | Health Plan Type | |
| Health Plan Address | | | Health Plan Phone |
| Subscriber Name | Relationship to Patient | Subscriber Date of Birth | |
| Subscriber Employer Name | Employment Status | Subscriber Phone | |

# MOUNT SINAI DOCTORS SENIOR HEALTH –
# COMPREHENSIVE QUESTIONNAIRE (Complete all pages front and back)

| **Insurance Plan Name (2)** | Group Name | Group Number |
|---|---|---|
| Policy Number | Health Plan Type | |
| Health Plan Address | | Health Plan Phone |
| Subscriber Name | Relationship to Patient | Subscriber Date of Birth |

**Demographic Verification**
**I have reviewed the demographic and insurance information provided on the facesheet. The above information is correct and accurate.**
**Patient Signature X**_____

Last revised: 07/12/2017

# MOUNT SINAI DOCTORS SENIOR HEALTH – COMPREHENSIVE QUESTIONNAIRE (Complete all pages front and back)

Mount Sinai

## A Message to Our Patients

**Hospitals are required to collect race and ethnicity information on all patients by the Department of Health (DOH). Racial and ethnic backgrounds may place people at different risks for certain diseases. By knowing more about your racial and ethnic background, we can better meet your health needs. Please review the selections on this card and select the ethnicity and race that best describes you.**

| RACE DESCRIPTION | |
|---|---|
| I | AMERICAN INDIAN OR ALASKA NATIVE |
| SEE BELOW | ASIAN |
| SEE BELOW | BLACK |
| SEE BELOW | NATIVE HAWAIIAN OR PACIFIC ISLANDER |
| W | WHITE |
| O | OTHER |
| U | UNKNOWN |

| ETHNICITY DESCRIPTION | |
|---|---|
| SEE BELOW | SPANISH/HISPANIC ORIGIN |
| N | NOT HISPANIC OR LATINO |
| U | UNKNOWN |

| ASIAN (Please Select One From the Options Below) | |
|---|---|
| AA | Asian Indian |
| AB | Bangladeshi |
| AC | Bhutanese |
| AD | Burmese |
| AE | Cambodian |
| AF | Chinese |
| AG | Filipino |
| AH | Hmong |
| AY | Indonesian |
| AJ | Iwo Jiman |
| AK | Japanese |
| AL | Korean |
| AM | Laotian |
| AO | Malaysian |
| AP | Maldivian |
| AQ | Nepalese |
| AR | Okinawan |
| AZ | Pakistani |
| AT | Singaporean |
| AU | Sri lankan |
| AV | Taiwanese |
| AW | Thai |
| AX | Vietnamese |

| BLACK (Please Select One From the Options Below) | |
|---|---|
| BA | African-American |
| BB | Barbadian |
| BC | Cape Verdian |
| BD | Congolese |
| BE | Dominica Islander |
| BF | Eritrean |
| BG | Ethiopian |
| BH | Gabonian |
| BJ | Ghanaian |
| BK | Grenadian |
| BM | Guinean |
| BN | Haitian |
| BO | Ivory Coastian |
| BP | Jamaican |
| BQ | Kenyan |
| BR | Liberian |
| AN | Madagascar |
| BS | Malian |
| BT | Nigerian |
| BU | Senegalese |
| BV | Sierra Leonean |
| BW | Somalian |
| BX | St Vincenian |
| BY | Sudanese |
| BZ | Tanzanian |
| B1 | Togolese |
| B2 | Trinidadian |
| B3 | Ugandan |
| B4 | West Indian |
| B5 | Zimbabwean |
| B6 | **Other:** East African |
| B7 | **Other:** North African |
| B9 | **Other:** West African |
| B8 | **Other:** South African |

| NATIVE HAWAIIAN OR PACIFIC ISLANDER (Please Select One From the Options Below) | |
|---|---|
| PA | Carolinian |
| PB | Chamorro |
| PC | Chuukese |
| PD | Fijian |
| PE | Guamanian |
| PF | Guamanian or Chamorro |
| PG | Kiribati |
| PH | Kosraean |
| P1 | Mariana Islander |
| PJ | Marshallese |
| PK | Melanesian |
| PL | Micronesian |
| PM | Native Hawaiian |
| PN | New Hebrides |
| PP | Palauan |
| PQ | Papua New Guinean |
| PR | Pohnpeian |
| PS | Polynesian |
| PT | Saipanese |
| PU | Samoan |
| PV | Solomon Islander |
| PW | Tahitian |
| PX | Tokelauan |
| PY | Tongan |
| PZ | Yapese |
| PO | **Other** Pacific Islander |

| SPANISH/HISPANIC ORIGIN (Please Select One From the Options Below) | |
|---|---|
| 1 | Andalusian |
| 2 | Argentinean |
| 3 | Asturian |
| 4 | Belearic Islander |
| 5 | Bolivian |
| 6 | Canal Zone |
| 7 | Canarian |
| 8 | Castillian |
| 9 | Catalonian |
| 10 | Central American |
| 11 | Central American Indian |
| 12 | Chicano |
| 13 | Chilean |
| 14 | Colombian |
| 15 | Costa Rican |
| 16 | Criollo |
| 17 | Cuban |
| 18 | Dominican |
| 19 | Ecuadorian |
| 20 | Gallego |
| 21 | Guatemalan |
| 22 | Honduran |
| 23 | La Raza |
| 24 | Latin American |
| 25 | Mexican |
| 26 | Mexican American |
| 27 | Mexican American Indian |
| 28 | Mexicano |
| 29 | Nicaraguan |
| 30 | Panamanian |
| 31 | Paraguayan |
| 32 | Peruvian |
| 33 | Puerto Rican |
| 34 | Salvadoran |
| 35 | South American |
| 36 | South American Indian |
| 37 | Spaniard |
| 38 | Spanish Basque |
| 39 | Uruguayan |
| 40 | Valencian |
| 41 | Venezuelan |

## CURRENT MEDICAL PROBLEMS

What brings you in today? _____

_____

_____

Where have you received medical care prior to this visit? _____

**OFFICE USE ONLY:** Provider's notes on chief complaint and present illness

_____

_____

_____

_____

_____

_____

_____

_____

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

1. _____ 8. _____
2. _____ 9. _____
3. _____ 10. _____
4. _____ 11. _____
5. _____ 12. _____
6. _____ 13. _____
7. _____ 14. _____

Have you had an allergic reaction or any other adverse reaction to any medications or food? ❑ Yes ❑ No

If yes, describe the medication(s) and/or food(s) and the adverse effect(s): _____

_____

What is the name and telephone number of your pharmacy? _____

If you have a prescription drug plan, does your plan allow you to get medications via mail order? ❑ Yes ❑ No

If yes, which mail order pharmacy and what is the phone number? _____

## PAST MEDICAL HISTORY

Is pain one of the reasons for your visit here today? ❑ Yes ❑ No If yes, rate your pain on a scale from 1-10: ___

Where is your pain? _____

Have you ever had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| High blood pressure | ❑ Yes ❑ No | Tuberculosis | ❑ Yes ❑ No | Anemia | ❑ Yes ❑ No |
| Heart attack | ❑ Yes ❑ No | Diabetes | ❑ Yes ❑ No | Cancer | ❑ Yes ❑ No |
| Other heart disease | ❑ Yes ❑ No | Osteoporosis | ❑ Yes ❑ No | Stroke | ❑ Yes ❑ No |
| High cholesterol | ❑ Yes ❑ No | Arthritis | ❑ Yes ❑ No | Depression | ❑ Yes ❑ No |
| Asthma | ❑ Yes ❑ No | Hepatitis | ❑ Yes ❑ No | | |

**(OFFICE USE ONLY)**_____

_____

Have you ever had any surgery? ❑ Yes ❑ No If yes, list the type or surgery and when:

_____

_____

Have your been hospitalized for other reasons besides surgery? ❑ Yes ❑ No If yes, list when and why:

_____

## FAMILY HISTORY

Do any of your family members have or did they have in the past any of the following conditions?

| | | | | | |
|---|---|---|---|---|---|
| High blood pressure | ❑ Yes ❑ No | Tuberculosis | ❑ Yes ❑ No | Stroke | ❑ Yes ❑ No |
| Heart attack | ❑ Yes ❑ No | Diabetes | ❑ Yes ❑ No | Dementia | ❑ Yes ❑ No |
| Other heart disease | ❑ Yes ❑ No | Hepatitis | ❑ Yes ❑ No | Glaucoma/Blindness | ❑ Yes ❑ No |
| Asthma | ❑ Yes ❑ No | Cancer | ❑ Yes ❑ No | Alcoholism | ❑ Yes ❑ No |
| | | | | Other _____ | |

**(OFFICE USE ONLY)**_____

**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 live alone or with someone? ❑ Alone ❑ With someone: _____

Are you a caregiver for someone else? ❑ Yes ❑ No If yes, for whom are you a caregiver? _____

Has anyone in your family or home every physically or verbally hurt you? ❑ Yes ❑ No

Do you have family and/or friends who help you out? (who would you call in case of an emergency?)

_____

_____

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

**HABITS:**

Do you currently smoke? ❑ Yes ❑ No If yes, how many packs per day?___ How many years have you smoked? ____
If you don't smoke currently, did you ever smoke? ❑ Yes ❑ No If yes, how many packs per day and how many years did you smoke? ____ packs per day _____ years
Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks per day? _____
Do you use any illicit drugs? ❑ Yes ❑ No If yes, what drug(s)? _____ Date Last used _____

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

| | Independent | Need Assistance | Can't Do At All |
|---|---|---|---|
| Preparing meals | ☐ | ☐ | ☐ |
| Managing money | ☐ | ☐ | ☐ |
| Managing medications | ☐ | ☐ | ☐ |
| Using telephone | ☐ | ☐ | ☐ |
| Shopping for groceries | ☐ | ☐ | ☐ |
| Getting places outside | | | |
| Short distance | ☐ | ☐ | ☐ |
| Long distance | ☐ | ☐ | ☐ |
| Dressing | ☐ | ☐ | ☐ |
| Grooming | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ |
| Getting in/out of bed or chair | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ |
| Bathing | ☐ | ☐ | ☐ |
| Using the toilet | ☐ | ☐ | ☐ |

Do you use any equipment to assist in your daily life? ❑ Yes ❑ No If yes, please check items you have:

❑ 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, what agency or agencies are involved in your care? _____

How many hours of help do you have each day/week? _____

## REVIEW OF SYMPTOMS

| | | Provider Notes |
|---|---|---|
| **Constitutional** | | |
| Recent weight change of more than 10 pounds | ❑ Yes ❑ No | |
| Poor appetite | ❑ Yes ❑ No | |
| Rashes or skin changes | ❑ Yes ❑ No | |
| Sleep problems | ❑ Yes ❑ No | |
| Frequent fevers/night sweats | ❑ Yes ❑ No | |
| Fatigue/weakness | ❑ Yes ❑ No | |
| **Eyes/Ears/Nose/Throat** | | |
| Wears glasses | ❑ Yes ❑ No | |
| Blurred vision/double vision | ❑ Yes ❑ No | |
| Difficulty hearing | ❑ Yes ❑ No | |
| Teeth/denture problems | ❑ Yes ❑ No | |
| **Musculoskeletal** | | |
| Painful or swollen joints | ❑ Yes ❑ No | |
| Leg cramps | ❑ Yes ❑ No | |
| Difficulty walking | ❑ Yes ❑ No | |
| Falls in the past 6 months | ❑ Yes ❑ No | |
| **Cardiopulmonary** | | |
| Chronic/frequent cough or blood in sputum | ❑ Yes ❑ No | |
| Shortness of breath | ❑ Yes ❑ No | |
| Palpitation/irregular heart beat | ❑ Yes ❑ No | |
| Chest pain/tightness | ❑ Yes ❑ No | |
| Swelling of feet/legs | ❑ Yes ❑ No | |
| **Gastrointestinal** | | |
| Trouble swallowing | ❑ Yes ❑ No | |
| Nausea/vomiting | ❑ Yes ❑ No | |
| Stomach pains | ❑ Yes ❑ No | |
| Diarrhea | ❑ Yes ❑ No | |
| Constipation or use of laxatives | ❑ Yes ❑ No | |
| Change in bowel habits | ❑ Yes ❑ No | |
| Blood in stool or black stools | ❑ Yes ❑ No | |
| **Endocrine** | | |
| Bothered excessively by hot or cold weather | ❑ Yes ❑ No | |
| Thirsty most of the time | ❑ Yes ❑ No | |
| **Hematologic/Lymphatic** | | |
| Bleeding/bruising easily | ❑ Yes ❑ No | |
| Lumps in neck, armpits, groin | ❑ Yes ❑ No | |
| **Neurological** | | |
| Frequent or chronic headache | ❑ Yes ❑ No | |
| Convulsions/seizure | ❑ Yes ❑ No | |
| History of mini strokes | ❑ Yes ❑ No | |
| Numbness/tingling | ❑ Yes ❑ No | |
| Paralysis/weakness | ❑ Yes ❑ No | |
| Dizziness/unsteadiness | ❑ Yes ❑ No | |
| Memory problems or forgetfulness | ❑ Yes ❑ No | |

**Psychiatric**

| | | |
|---|---|---|
| Depressed or sad | ❑ Yes ❑ No | _____ |
| Nervous or anxious | ❑ Yes ❑ No | _____ |
| Attempted suicide or suicide thoughts | ❑ Yes ❑ No | |

**Genitourinary**

| | | |
|---|---|---|
| Frequent urination | ❑ Yes ❑ No | _____ |
| Frequent nighttime urination | ❑ Yes ❑ No | _____ |
| Burning or pain on urination | ❑ Yes ❑ No | _____ |
| Blood in urine | ❑ Yes ❑ No | _____ |
| Leakage of urine | ❑ Yes ❑ No | _____ |

**Women only**

| | | |
|---|---|---|
| Age at menopause | Age: _____ | _____ |
| Vaginal bleeding after menopause | ❑ Yes ❑ No | _____ |
| Discharge or lump in breast | ❑ Yes ❑ No | _____ |

**Men only**

| | | |
|---|---|---|
| Sore or lump on penis or testicles | ❑ Yes ❑ No | _____ |

**SEXUAL HISTORY** Sexually active? ❑ Yes ❑ No Sexual preference ❑ Heterosexual ❑ Homosexual

**PREVENTIVE CARE**: Please indicate if you have had the following preventive tests, and give approximate dates.
Last eye examination _____ Last dental visit _____
Last bone density test _____ Last Colonoscopy _____
**Women only:** Last mammogram _____ Last Pap test _____
Have you received any of the following vaccinations?
Influenza (flu) ❑ Yes ❑ No ❑ Unknown
Pneumococcal pneumonia ❑ Yes ❑ No ❑ Unknown
Shingles ❑ Yes ❑ No ❑ Unknown
**Provider notes:** _____

**ADVANCE DIRECTIVES:**
Have you appointed someone to make decisions for you about your health in the event that you are unable to do so? ❑ Yes ❑ No ❑ Unknown If yes, who is that person? _____
Please provide a copy for our records.

Do you have a Living Will? ❑ Yes ❑ No

**MISCELLANEOUS**: (For any extra notes)

_____

_____

_____

_____

_____

_____

_____

## NSI CHECKLIST TO DETERMINE YOUR NUTRITIONAL HEALTH

*Assign* **1** *point if Yes,* **0** *if No*

I have an illness/ condition that made me change the kind or amount of food I eat _____

I eat fewer than two meals a day _____

I eat few fruits or vegetables, or milk products _____

I have three or more drinks of beer, liquor or wine almost everyday _____

I have tooth or mouth problems that make it hard for me to eat _____

I don't always have enough money to buy the food I need _____

I eat alone most of the time _____

I take three or more different prescribed or OTC drugs a day _____

Without wanting to, I have lost or gained 10 pounds in the last 6 months _____

I am not always physically able to shop, cook, or feed myself _____

**Total nutritional score** _____

*0-2 indicates good nutrition; 3-5 indicates moderate risk; 6 or more indicates high nutritional risk*

*Reprinted with permission by the Nutritional Screening Initiatives, a project of the American Academy of FamilyPhysicians, the American Dietetic Association and the National council on the Aging, Inc., and funded in part by a grant from Ross Products Division, Abbot Laboratories, Inc.*

Please write what you ate in the last 24 hours.

Breakfast:

_____

_____

Lunch:

_____

_____

Dinner:

_____

_____

Snack:

_____

_____