Medical History Questionnaire

Kindly complete and return this form to our office by fax or mail at your earliest convenience, and keep a copy for yourself. Please bring your copy to your first appointment. Depending on the complexity of your medical history, this form may require 1-2 hours for completion. Please do not be concerned if you cannot complete the entire form. We will review it at your visit. Thank you in advance for your effort!

Patient's name: _____

Name of person completing this form: _____

Patient's date of birth: _____

Date moved to current residence: _____

Facility name and Apartment or Room number: _____

Telephone Number: _____

Date moved to current facility: _____

If you live in a senior living facility, please list the main reason(s) for your move to this residence. If you live in a private home or apartment, please list the main reason(s) you have difficulty leaving your residence completely unaided. Please place a check any that apply, and write in any other factors.

- ☐ unsteady gait, or need for walker or assistance of another person to avoid falling
- ☐ general weakness or very limited stamina
- ☐ need to be accompanied by another person for safety
- ☐ no longer able to manage alone in a private home due to declining physical capacity
- ☐ no longer able to manage alone at home due to declining mental faculties
- ☐ unable or afraid to leave home due to emotional or behavioral issues

_____

_____

_____

_____

_____

_____

MEDICATIONS:

Please list all medications you are currently taking.
List **name, strength,** and **number of times per day** each medication is taken. For example: Zocor 20 mg 1 tablet daily. Another example: Tylenol 325 mg 1-2 tablets every 4 hours for pain, taken an average of 2 times per week.

1. Please list prescription medications first.
2. Next, list all over-the-counter medications used at least once per month, such as aspirin, Tylenol, Advil, Aleve, antacids, laxatives, stool softeners, sleeping aids, etc. Again, list name, dosage and number of times per day (or week) each is taken.
3. Finally, list all vitamins, minerals, supplements, herbal remedies, laxatives, suppositories, fiber supplements. Please list name, dosage (mg or IU, if listed on label) and how many are taken per day. For multivitamins, please note the name of the multivitamin (e.g., Theragran-M or Centrum Silver).

Name	**Strength**	**Number of times per day**

Please attach another page if needed.
Please carefully review the above for accuracy and completeness, and remember to list over-the-counter items and supplements.

ALLERGIES and ADVERSE REACTIONS:

Please list any medication, food or other item that you are allergic to or have had a bad reaction to. Please note the type of reaction to each item, and if recalled, approximately when this occurred. Include any medications that did not agree with you, such as medications that caused upset stomach, dizziness, weakness, sleepiness, confusion, swollen ankles, etc. If you need more room, please attach another page.

Name of item Type of Reaction

_____
_____
_____
_____
_____
_____

Tobacco Use

Have you ever smoked or chewed tobacco products? ☐ Yes ☐ No
If you answered no above, please proceed to the section below on alcohol use.
Are you a *currently* a cigarette smoker? ☐ Yes ☐ No
If Yes, would you like to quit? ☐ Yes ☐ No
If you are a former cigarette smoker, what year did you quit? _____
For how many years did you smoke cigarettes? _____.
How many packs per day, on average? _____
If you have ever used cigars, a pipe, chewing tobacco or snuff on a regular basis please note for how long and how often: _____.

Alcohol Use

Do you currently drink alcoholic beverages (beer, wine or liquor)? ☐ Yes ☐ No
If yes, how many drinks per week, on average? _____.
(One drink equals 12 oz. of beer, 5 oz. of wine, 1 oz. of liquor or spirits)
At any time in your life, were you an alcoholic or heavy drinker? ☐ Yes ☐ No

Prescription Pain Medication
Have you ever used strong pain-killers for more than two weeks (e.g. Percocet, Oxycontin, Duragesic patch, Vicodin, Codeine, Fiorinal, Fioricet, Ultram, Tramadol, Soma) or sedatives (e.g. Valium, Ativan, Xanax, Librium, Equanil, Miltown, Phenobarbital, Nembutal, Seconal)? ☐ Yes ☐ No
Have you used any of the above in the past 6 months? ☐ Yes ☐ No

Sleeping Pills
Have you ever used prescription or over-the-counter sleeping pills for more than one week, such as Tylenol PM, Ambien, Zolpidem, Sonata, Lunesta, Halcion, Dalmane, Restoril, Temazepam, Trazodone, Benadryl, Sleep-Eze, or Unisom? ☐ Yes ☐ No
Have you used any of the above in the past 6 months? ☐ Yes ☐ No

Your Specialists:

Please list the names of any physician specialists whose care you are under now, or have been under in the past 5 years.

Specialty	Name
Internal Medicine or Family Practice	
Cardiology	
Pulmonology	
Gastroenterology (please list even if only seen for colonoscopy)	
Endocrinology	
Rheumatology	
Hematology/Oncology	
Allergy	
Dermatology	
Nephrology	
Neurology	
Ophthalmology	
Psychiatry	
Urology	
Orthopedics	
General Surgeon	
Gynecology	

Other	
Other	
Other	

Your Preferred Hospital.

Should you require hospitalization, what hospital do you prefer? Please note that in an emergency, the ambulance crew is required to take you to the nearest emergency room.

_____ Suburban Hospital
_____ Sibley Hospital
_____ Shady Grove Adventist Hospital
_____ Holy Cross Hospital
_____ National Naval Medical Center (Bethesda Naval Hospital)
_____ Walter Reed Army Medical Center
_____ Other: _____

MEDICAL CONDITIONS:

Please make a check mark next to any medical condition listed below which you have been diagnosed with. Please also note year (or decade) of diagnosis. The list is extensive to help ensure that I have your complete history; please do not be concerned if you do not recognize all of the terms; in fact, be glad if you don't!

Hypertension (high blood pressure) _____
Diabetes _____
High Cholesterol _____

Heart and Related Disorders
Heart attack (myocardial infarction) _____
Angina _____
Coronary artery disease _____
Bypass surgery _____
Angioplasty or stent _____
Congestive heart failure _____
Atrial fibrillation _____
Arrhythmia _____
Rheumatic fever _____
Heart murmur _____
Heart valve problem _____
Any other heart condition _____
PAD (peripheral arterial disease) _____
Abdominal aortic aneurysm _____

Neurologic Disorders
Stroke _____
TIA _____
Seizure or epilepsy _____
Dementia _____
Parkinson's disease _____
Peripheral neuropathy _____
Other neurologic condition _____

Lung Disorders
Emphysema or COPD _____
Asthma _____
Chronic bronchitis _____
Tuberculosis _____
Any other lung condition _____

Gastrointestinal Disorders
Colon Polyp _____
Diverticulosis or diverticulitis _____
Colitis _____
Ulcer _____

Reflux or GERD _____
Hiatal hernia _____
Other stomach or intestinal disorder _____
Gallstones _____

Blood Disorders
Anemia _____
Blood clot in leg (phlebitis, DVT) _____
Any other blood disorder _____

Miscellaneous
Shingles _____
Cancer of any type, except skin _____
Skin cancer _____
Depression _____
Anxiety or other nervous disorder _____
Alcoholism _____
Arthritis (specify joints affected) _____
Gout _____
Sleep apnea _____
Goiter _____
Hypothyroidism _____
Other thyroid disorder _____
Hepatitis or other liver disorder _____
Kidney or urinary tract infection _____
Renal insufficiency (weak kidneys) _____
Kidney stones _____
Any other kidney disorder _____
Incontinence of urine _____
Incontinence of stool _____
Cataracts _____
Glaucoma _____
Macular degeneration _____
Hearing loss _____

REVIEW OF SYMPTOMS:

Whew! You deserve a rest if you've come this far. In fact, please feel free to take one, lest you add eye fatigue and writer's cramp to the list of bodily symptoms below! This section is designed to help me understand some of the symptoms or problems you might be having now, or which you had in the recent past. Please use the space at the right or attach another page if needed.

Do you use any of the following:

Glasses _____
Dentures _____
Hearing Aid _____. If yes, which ear(s)? _____
Cane _____
Walker _____
Wheelchair _____
Motorized Scooter _____

Do you require any assistance with any of the following?

Bathing _____
Dressing _____
Grooming (brushing hair and teeth, shaving) _____
Toileting, including hygiene afterward _____
Eating, including cutting food _____
Walking, including use of a cane _____
Getting up from a chair or bed _____

Using a telephone _____
Shopping _____
Food Preparation _____
Housekeeping _____
Laundry _____
Transportation _____
Organizing and taking medication _____
Paying Bills _____
Managing Finances _____

In the past **6 months** have you had any of the below problems?

Weight gain or loss of more than 10 pounds _____
Depressed or "blue" mood for more than 2 weeks _____
Felt hopeless, lonely or sad for more than 2 weeks _____
Lack of motivation or interest in activity _____
Uncharacteristic irritability or anger _____
Difficulty with nervousness or anxiety _____
Difficulty falling or staying asleep _____
Excessive daytime sleepiness _____

Headaches _____
Memory problem _____
New or worsened problem with vision _____
Difficulty hearing _____
A fall in the past **12** months _____
(For any falls in the past 12 months, please describe where and why this occurred, and whether any injury occurred. Attach another page if needed.)
Pain, pressure, or heaviness in your chest upon exertion _____
Any other chest discomfort (please describe)_____
Difficulty breathing upon activity _____
Difficulty breathing any other time _____
Swollen ankles _____
Palpitations or fluttering in chest _____
Fainting or sudden loss of consciousness _____
Cough lasting more than 1 month _____
Coughing of blood _____
Heavy sweating at night _____
Awakening at night for any reason *except* for needing to urinate _____
Loss of appetite _____
Persistent difficulty swallowing _____
New or worsened heartburn _____
New or worsened stomach bloating or pain _____
New constipation _____
New onset of loose stools _____
Change in stool caliber to pencil-thin _____
Blood in stools (not just on toilet tissue) _____
Black, soft, tar-like stools _____
Nighttime urination more than once nightly _____
If yes, how times per night, now? _____
How many times per night 1 year ago? _____
New or worse difficulty in passing urine _____
Incontinence of urine _____
If yes, please describe how often this occurs, amount and typical circumstance, e.g. when can't get to the bathroom within 5-10 minutes, when cough or sneeze, when asleep, when urge to urinate occurs. Have exercises, biofeedback or any medications been tried? Attach another page if needed.
Blood in urine _____
Sexual difficulty _____

Have you **ever** had any of the below problems?

Temporary weakness, clumsiness or loss of sensation in an arm or leg _____
Temporary loss of vision _____
Temporary difficulty with speech _____
Sudden loss of consciousness or fainting _____
(If yes, please describe exactly what happened, and when, using back of this page.)

And for **women only**:

In the past 6 months have you had any of the below?

Vaginal bleeding _____
Vaginal discomfort or itching _____
Vaginal discharge _____
Pain during intercourse _____

Are there any other symptoms or concerns you would like to discuss with your doctor? If more room is needed, please attach another page.

_____
_____
_____
_____
_____
_____
_____

DIET and EXERCISE:

Do you regularly exercise for at least 30 minutes at least 3 days per week?
Yes ___ No ___. If yes, please describe your regimen.
_____

Do you closely follow any special diet? Yes ___ No ___
If yes, please describe.
_____
_____

On average, how many servings per day of calcium-rich food do you consume?

Food Item	Serving Size	# Servings Daily
Milk	8 oz	
Yogurt	8 oz	
Cottage cheese	½ cup	
Other cheese	1 oz	
Ice cream, frozen yogurt	1 cup	
Soy milk	1 cup	

SURGERY:

Please list all operations you have *ever* had, and the year (or your age) when performed. It's OK if year or age is not exact. If done in the past 10 years, also list surgeon's name and hospital name/location where any major surgery was performed if you can recall this information. Some common surgeries and procedures are listed below; please place a check mark in the box next to any you've had, and write in any details (year or age, name of surgeon/hospital).

☐ Pacemaker insertion _____
☐ Coronary Artery Bypass Surgery _____
☐ Angioplasty or Stent _____
☐ Appendectomy_____
☐ Cholecystectomy (gallbladder removal) _____
☐ Hysterectomy _____
☐ Removal of ovaries (often done with above) _____
☐ TURP (prostate surgery to improve urination) _____
☐ Cataract removal and year done: R eye _____ L eye _____
☐ Hip or knee replacement _____
☐ Hernia repair _____
☐ Mastectomy _____
☐ Tonsillectomy_____

Any other surgeries:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please review the above for completeness, and remember to write in what year or your age (approximate is OK) the surgery was done.

Please also note any complications after the above surgeries, such as infection, blood clot, pneumonia, heart attack, stroke, confusion, or anesthetic reaction.

OTHER HOSPITALIZATIONS:

Please list all hospitalizations, *other than those already covered above in the section on surgeries.*

Please tell me:

- the **reason or diagnosis** for which hospitalization was required
- the **year** in which this occurred (approximate is OK)
- whether you spent any time in a rehabilitation facility following the hospitalization, and if so, how long
- in the case of hospitalizations in the past 10 years, please also tell me the hospital name, city and state

As a reminder, here is a list of common reasons for hospitalization: fever, confusion, weakness, chest pain, trouble breathing, numbness, paralysis, speech difficulty, fainting spell, loss of consciousness, diarrhea, vomiting, abdominal pain, need for blood transfusion, need for testing or monitoring. Here is a list of some common diagnoses made during hospitalization: congestive heart failure, angina, heart attack (myocardial infarction), pneumonia, COPD exacerbation, urinary tract infection, other infection, dehydration, gastroenteritis, bowel obstruction, diverticulitis, phlebitis or blood clot.

MEDICAL PROCEDURES AND TESTS:

If you have ever had any of the following procedures or tests, please give year of procedure, where or by whom done and the result, if known

Colonoscopy:

_____
_____

Upper endoscopy or EGD:

_____
_____

Stress test in the past 5 years.

_____
_____

Cardiac catheterization:

_____
_____

Echocardiogram:

_____

CT scan or MRI scans of brain, chest or other body part in the past 5 years.

_____
_____

Sonogram, ultrasound or other test on carotid arteries (arteries in your neck) in the past 5 years.

_____

FAMILY MEDICAL HISTORY:

Has a parent, sibling or child had any of the following:

Condition	**Relation**
Hip fracture	_____
Colon cancer	_____
Colon polyp	_____
Breast cancer	_____
Diabetes	_____
Heart attack	_____
Alzheimer Disease	_____
Parkinson’s Disease	_____
Familial tremor	_____
Thyroid problem	_____

Please provide the following information about parents and siblings.

Relation	Alive?	If deceased, age at death	If alive, current age	Major health conditions, and if deceased, cause of death.
Mother				
Father				
Bro/Sis (circle one)				
Bro/Sis				
Bro/Sis				
Bro/Sis				
Bro/Sis				

Children. List names, ages, and current health status.

_____ _____
_____ _____
_____ _____

Screening Tests and Preventive Measures:

When was your last…

Pneumonia vaccine? _____
Flu vaccine? _____
Tetanus booster? _____
Hearing test? _____
Eye check-up by MD? _____
Bone density test? What was result? _____
Shingles vaccine? _____

And, for women only:

When was your last…

Mammogram? Result?_____
PAP smear? Result? _____
Have you ever had an abnormal PAP smear? _____
Do you examine your breasts for lumps each month? _____

Driving and riding in cars:

Do you drive? ☐ Yes ☐ No
If no, when did you stop driving, and why? _____
_____
_____
If you drive, have you had any accidents or gotten lost in the past year? ☐ Yes ☐ No
Do you always wear your seatbelt? ☐ Yes ☐ No

Marital Status, Education, Occupation, Hobbies:

Marital Status (please circle all that apply):
Married once, Married more than once, Widow/Widower, Divorced, Never married

Highest grade of schooling or degree completed: _____

Previous Occupation(s) and date of retirement: _____

_____

Past and current hobbies and activities you enjoy:
_____

_____

Where were you born and raised?
_____

_____

Is there anything about your life story that you would like your physician to know?

_____

_____

Special Instructions and Advance Directives:

A delicate and important matter.

We strive to understand and abide by your wishes for your medical care. It is possible that due to illness, disease or injury you will be unable to make medical decisions for yourself. If this were to occur, it would be helpful (for your family and your doctor) to know in advance your wishes regarding your medical care in certain circumstances. Information about medical advance directives and a sample form are available from the State of Maryland at http://www.oag.state.md.us/Healthpol/adirective.pdf. You or your health care decision maker can revise your advance directive at any time, and we are happy to discuss this issue with you

Heroic Measures. Examples are CPR (cardiopulmonary resuscitation), defibrillation (electrical shocking in an attempt to bring back a normal heart beat) and mechanical ventilation (in which a tube is placed in the windpipe and the patient is connected to a machine called a ventilator). Please understand that contrary to what is usually depicted on TV and in the movies, heroic measures, when applied to frail, elderly persons, have a satisfactory outcome about 1% or less of the time, and about 10% of the time for younger persons. Frail elders who do survive resuscitation usually die a short time later (hours or days and occasionally weeks), after contending with broken ribs (a normal consequence of effective CPR), brain damage, and/or marked debilitation. We have never met a physician or nurse familiar with heroic measures who would want heroic measures applied to themselves or their loved ones when they are elderly and frail. However, the decision is yours, and we will abide by it.

Instructions about such procedures are often specified in a medical advance directive. The standard advance directive form available from the State of Maryland gives three scenarios in which you can decline heroic measures. These are:

1. When death from a terminal condition is imminent, and even if life-extending procedures are used there is no reasonable expectation of recovery.
2. A persistent vegetative state (e.g., coma) and no reasonable expectation of recovery.
3. An end-stage condition resulting in severe and permanent deterioration with incompetency and complete physical dependency.

There are two scenarios missing from the above list. Some patients do not want heroic measures at all. They do not want to wait for one of the dire and narrowly constructed scenarios above before heroic measures are withheld. If you want no heroic measures at all, from now on, e.g. when death from natural causes is imminent due to a recent illness or in the event of a sudden collapse, then consider adding this wish to your advance directive.

If you want no heroic measures at all in the event you develop dementia such that you no longer can live alone, and require a 24-hr aide or an assisted living or nursing facility, then consider adding this wish to your advance directive. Without these additions to your advance directive, if you have the standard Maryland advance directive, and have opted not to receive heroic measures under the 3 scenarios above, you will receive heroic measures until one of the 3 scenarios applies or your health care agent instructs othewise.

Hospitalization and Feeding Tubes.

There are two other areas beside heroic measures where we seek your instructions.

Hospitalization. Over the years, many patients have told us that if, as a result loss of mental faculties, they are no longer able to live independently, e.g. they require a 24-hour aide or need to live in assisted living or a nursing home, they would not want to be hospitalized or receive invasive or aggressive treatment. Instead, they would like to be cared for in their home, assisted living or nursing facility, and afforded comfort measures and simple medical care such as oral medication. For example, if they develop a condition that ordinarily would be treated in a hospital, such as pneumonia, heart attack, or stroke, they would rather have their care limited to comfort-oriented measures at home, plus simple medical care such as oral medications. Hospitalization would be used only if needed for comfort, such as repair of a fractured hip, or implantation of a pacemaker to prevent fainting/falls. This approach to care is often appropriate in later stages of dementia.

If I develop dementia that has progressed to the point that I require a 24-hour aide or residence in an assisted living or nursing facility, then I would like my health care agent to know that I (circle one and strike out the other): would would not want to be hospitalized, unless necessary for comfort measures.

Another important health care decision we sometimes face is whether to implant a feeding tube, should you lose the ability to eat or swallow in the setting of dementia or suffer a stroke with loss of both swallowing and medical decision making ability. It is helpful if you or your health care decision maker consider this situation in advance, and advise us on your wishes. Feeding tubes are not appropriate in the late stages of dementia, as they tend to cause pneumonia and other complications. In addition, to the best of our knowledge, such patients do not suffer from hunger or thirst.

If I am unable to speak for myself due to dementia or other loss of mental faculties, and have lost the ability to swallow, I would like my health care agent to know that I (circle one, and strike through the other)
would would not want a feeding tube used to prolong my life.

Do you have a medical advance directive? ☐ Yes. ☐ No.

Have you appointed a health care decision maker (also called a health care power of attorney)? ☐ Yes ☐ No

If yes, please bring me a copy to place on your chart. If not, please ask me how you can get one. In either case, at your visit please let me know of any directives or wishes regarding life-extending procedures, and your medical care in general. Feel free to make notes on the next page to guide our discussion.

_____
_____
_____
_____
_____
_____

Thank you for completing this form. It will help us take better care of you. We would appreciate your feedback on any way we can improve this questionnaire.

Sincerely,

Roy Fried, MD
Gary Wilks, MD
Premier Senior Care