Bristol Health
Medical Group
Geriatric Care

Date: ________

BHMG Geriatric Medicine New Patient Questionnaire

Demographics

What is your legal name? ____________________ What would you like us to call you? ____________

Date of Birth: ____________________

Address: ____________________

Phone #: ____________________

Email Address:

Power of Attorney/Health Care Representative

Name: ____________________

Phone #: ____________________

Primary Care Provider (PCP)

Name: ____________________

Phone #: ____________________

Address: ____________________

Social/Living Situation

Do you live in a......
- o Single-family house
- o Assisted Living
- o Apartment
- o Other (describe):

With whom do you live?
- o Alone
- o Spouse/partner
- o Other family member (specify):
- o Other, not family (specify):

Advance Directive

Do you have an Advance Directive?
- o Yes
- o No

Do you have a living will?
- o Yes
- o No

Education/Occupation History

How far did you go in school? ____________________

How old were you when you retired? ____________________

What was your last job position before you retired? ____________________

Hobbies/Interests/Activities

____

____

Medical/Surgical History

____

____

Social History

Have you ever smoked cigarettes? o Yes o No
If yes, how long did you smoke for and how many cigarettes a day? ____________________

Do you drink alcohol, including beer and wine, or other alcohol? o Yes o No
If yes please list: ____________________

Family History

What diseases run in the family? (E.g. Dementia, heart disease, stroke) ____________________

____

Medications/Immunizations

List all medications that you use. (Include all prescriptions, over the counter medications, nutritional supplements, vitamins and herbal remedies)

Current Medications	What Strength	How do you use it? How many times a day?
Example: Tylenol	500mg	1 pill 3x a day

Do you have any meds/allergies which cause intolerable side effects? o Yes o No
If yes please list: ____________________

Immunizations/Vaccinations	Date Received
Flu	
Shingles	
Pneumonia	
COVID	
RSV	

Please list any specific geriatric health concerns that you would like your doctor to know about before your visit. Please be sure to include any information not reported in this form.

____

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Social Support

Question		
If you need any extra support, can you count on anyone to help you with daily tasks like grocery shopping, house cleaning, cooking, telephoning, giving you a ride, etc.?)	o Yes	o No
If yes, who? ______		
Can you count on anyone to provide you with any emotional support such as talking out problems or helping you make decisions?	o Yes	o No
If yes, who? ______		
If you need some extra help financially, can you count on anyone to help you, for example, by paying bills, housing costs, hospital visits, providing you with food/clothes, etc.?	o Yes	o No
If yes, who? ______		

Safety Assessment

Question		
Is the patient still driving?	o Yes	o No
Is the patient taking medication as prescribed?	o Yes	o No
Are there concerns about safety in the home?	o Yes	o No
Has the patient gotten lost in familiar places or wandered?	o Yes	o No
Are there any firearms in the home?	o Yes	o No
Has the patient experienced unsteadiness or sustained falls?	o Yes	o No

Is there anything else you'd like to share about the patient's safety? o Yes o No

If yes please list: ______

Thank you for choosing Bristol Health Geriatric Care. We're honored to have the opportunity to serve you or your loved one. Our dedicated team is committed to providing compassionate and personalized care for you. We extend a warm welcome to our practice and look forward to partnering with you on your journey towards optimal health and wellness in aging.

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Geriatric Care

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In preparation for your evaluation at the Bristol Health Geriatrics office, please answer the following questions completely and with as much detail as possible. You may wish to have a family member or caregiver who knows you well assist you with this questionnaire.

If the patient was unable to complete this form, please indicate who completed it.

Printed Name   Relationship to Patient

To the best of my knowledge, the responses given in this questionnaire are an accurate representation of the patient's health and medical history.

Caregiver Signature   Date