

## Geriatric Health Questionnaire

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** Please circle answers.

**1. General Health:** In general would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

**2. Activities of Daily Living:** Do you need help or can you do it yourself?

Walking	Need Help	Do Myself
Dressing	Need Help	Do Myself
Bathing	Need Help	Do Myself
Eating	Need Help	Do Myself
Toileting	Need Help	Do Myself
Using Telephone	Need Help	Do Myself
Shopping	Need Help	Do Myself
Housework	Need Help	Do Myself
Taking Medication	Need Help	Do Myself
Driving	Need Help	Do Myself
Paying Bills, Banking	Need Help	Do Myself

**3. Geriatric Review of Systems:**

- a. Do you have difficulty driving, watching TV,  
or reading because of poor eyesight?..... Yes / No
- b. Can you hear normal conversational voice?..... Yes / No  
Do you use hearing aides? ..... Yes / No
- c. Do you have problems with your memory? ..... Yes / No
- d. Do you often feel sad, lonely or depressed? ..... Yes / No

e. Have you unintentionally lost weight in the last 6 months? ..... Yes / No

f. Do you have trouble with control of your bladder? ..... Yes / No

Do you have trouble with control of your bowels? ..... Yes / No

g. How many falls have you had in the past year? \_\_\_\_\_

h. Do you drink alcohol? ..... Yes / No

If yes, how many drinks per week? \_\_\_\_\_

4. Do you live with anyone?

Spouse

Child

Relative

Friend

Who would help you in an emergency? \_\_\_\_\_

Who would help you with health care decisions if you were not able to communicate your wishes? \_\_\_\_\_

5. What is your system for taking your medications?

Pill Box

Help from family or friend

Other

6. Are you sexually active? ..... Yes / No

7. Has anyone intentionally tried to harm you? ..... Yes / No

8. Have you had a shot to prevent pneumonia? ..... Yes / No

9. Please draw the face of a clock with all the numbers and the hands set to indicated 10 minutes after 11 o'clock.