QUESTIONNAIRE FOR GERIATRICIAN CLINIC

PATIENT DETAILS:

Surname:_______________ **Given Name:** _______________ **Title:** ________ **Gender:** F / M

Preferred Name:_______________ **Date of Birth:** _______________

Address: _______________ **Suburb:**___________ **Post Code:**___________

Phone: _______________ **Mobile:** _______________

Email: _______________

Medicare Number/ DVA number: _______________ **No.** **Expiry Date:**_______________

NEXT OF KIN/EMERGENCY CONTACT

Surname:_______________ **Given Name:** _______________ **Title:** ________

Relationship: _______________ **Phone:** _______________ **Mobile:** _______________

Address: _______________ **Suburb:**___________ **Post Code:**___________

Email: _______________

Please list all Doctors/Specialists you are currently seeing, that you would like us to send a correspondence to:

Name: **Address:**

____

____

____

What is the main reason for the referral to the geriatrician? _______________

How long has this been going on for? _______________

____

What problem is it causing you or your family? _______________

____

Please note <u>in order,</u> up to two things you specifically hope can be helped or improved as a result of your visit with the geriatrician.

1. _______________

   ____

2. _______________

   ____

HEALTH QUESTIONNAIRE

Have you, or are you being treated for any of the following conditions? If yes, please provide a brief description. (Please tick)

	Yes	No	If yes, comment:
Blood Pressure?	O	O	______________________________
Diabetes?	O	O	______________________________
Heart Problems?	O	O	______________________________
Lung problems?	O	O	______________________________
Stroke?	O	O	______________________________
Parkinson Disease?	O	O	______________________________
Arthritis?	O	O	Where:__________________________
Problems with balance or walking?	O	O	______________________________

How many falls have you had in the past year? ______What happened?_______________

____

Memory Problems?	O	O	______________________________
Depression/ Anxiety?	O	O	______________________________
Sleeping Problems?	O	O	______________________________

How is your appetite and weight? ______________________________

Bowels? ______________________________

Urine or bladder control? ______________________________

Hearing? ______________________________

Vision? ______________________________

When were you last in hospital? _________ Which one? ______________________________

Why? ____

When was your last pathology test: ____________ **At the pathology service:** ____________________

Have you had an operations or other major health problems not covered so far? If yes, please list with a brief overview and approximate year?

____

____

Is there a family history of any significant or similar illnesses with your parents or siblings?____

When were you last vaccinated for Flu?__________Pneumococcal? ___________

shingles? ___________ Whooping Cough? _________CoVid 19? _______

SOCIAL ASPECTS

	Yes	No	
Do you smoke?	O	O	If yes, how many daily? _______________________________
Did you smoke in the past?	O	O	What year did you quit?_______________________________
Do you drink Alcohol?	O	O	If yes, how much per day?_____________________________
Previous main employment?			____
What form of exercise do you partake in?			____
Do you live alone?	O	O	If no, who do you live with? ___________________________
Do you drive?	O	O	If yes, do you have any problems? ______________________

____

Do you feel you are managing well in your current living circumstances? Yes / No
If no, please give a brief explanation: ____

____

Do you need assistance to do any tasks or personal care that you could previously manage?

____

What support services if any are you receiving? ____

____

Have you nominated an Enduring Power of Attorney? ____

Have you arranged a Medical Power of Attorney/ Medical decision treatment maker? Who have you nominated? ____

How many years ago did you write your will? ____

Are you <u>ALLERGIC</u> to any medications? Yes / No **If yes, please list:** ______________________________

<u>If your chemist organises your medications, please write their name and contact details:</u>

____

____

Please write down <u>ALL</u> Medicines, drops, creams, vitamins, herbs etc you are currently using/taking :

NAME	STRENGTH	FREQUENCY
___________________________	_____________	_____________
___________________________	_____________	_____________
___________________________	_____________	_____________
___________________________	_____________	_____________
___________________________	_____________	_____________
___________________________	_____________	_____________
___________________________	_____________	_____________
___________________________	_____________	_____________
___________________________	_____________	_____________

ACKNOWLEDGMENT OF INFORMATION: (Please tick the following to show you have read the below information)

- The staff of Age Right has advised me of the cost of my appointment and I am responsible for paying my account in full on the day of my consultation.
- If I cancel my appointment without reason and do not give 24 hours' notice, I understand I may incur a cancellation fee.
- I give permission for the staff of Age Right to request further medical information from my GP, hospital, pathology, radiology, other specialist and other health services as discussed during my consultation.
- I give permission for the doctor to contact family members as needed.
- I may nominate a contact to have access to the patient portal. This portal holds the letters and investigations organised by Age Right doctors.
- **Name and Contact Details of Person Responsible for payment of account.**
  Name: ____________________________ Ph:_________________________
  Address:____
  Email Address:____

Privacy statement:

As a patient of Age Right, my medical records and personal information will be maintained throughout my treatment. Such records will contain information which will include, my personal details and referring doctor's details. During the period of assessment for treatment and ongoing management, relevant clinical details and results will be recorded in my patient file. These records will be securely stored and only accessed by staff members of Age Right for the purpose of my treatment. I understand my medical records will be securely stored for 7 years following my last consultation. If necessary, I consent for my medical records to be shared with other health professionals/practitioners strictly for the purpose of my treatment. In certain circumstances, there may be a legal obligation to disclose clinical information. A full copy of Age Right privacy policy is available if I request it. Access to the patient portal which holds my letters from Age Right and investigations will be discussed at my first appointment and granted to an account holder.

I, ____acknowledge and agree to these terms and conditions.

Signature: ______________________________________ Date: ____