

**PRIMARY CARE AND PREVENTION CENTER  
DEPARTMENT OF COMMUNITY & FAMILY MEDICINE  
SLUCare @ Des Peres**

Senior Adult (age 65 or older) Health Questionnaire

**Patient name:** \_\_\_\_\_ **Birth date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Today's date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

The following questionnaire will help us provide high quality care for your child.  
Please fill in the following information as completely as possible.

List medications and reasons for taking them.  
(List non-prescription medicines also)

List medication or latex allergies or intolerances.  
(List reaction and side effect of each medication)

Medications with Dose	Reasons for Taking It	Types of Medication	Reactions/Side Effects

**Hospitalizations (Illnesses or Operations):**

\_\_\_\_\_  
\_\_\_\_\_

**Family Medical History**

Please check where you or members of your family, have had the following:

**Immunizations**

**Estimated date**

Tetanus booster: \_\_\_\_\_  
Flu vaccine: \_\_\_\_\_  
Pneumonia vaccine: \_\_\_\_\_

**Habits - Any problems with:**

Smoking N  Y  Packs per day: \_\_\_\_\_  
Alcohol N  Y  Drinks per day: \_\_\_\_\_  
Exercise N  Y   
Method(s): \_\_\_\_\_  
Days per week: \_\_\_\_\_

Healthy diet Y  N

**Social History:**

Married? Y  N   
Who do you live with? \_\_\_\_\_  
Occupation: \_\_\_\_\_

Do you have a Living Will/Advanced Directive? Y  N

Pets: \_\_\_\_\_  
\_\_\_\_\_

List health concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

	Yoursel	Father	Mother	Father's Side	Mother's Side	Brother(s)	Sister(s)
	a	b	c	d	e	f	g
Abuse							
AIDS							
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bleeding Problem							
Cancer							
Cirrhosis							
Dementia							
Depression							
Diabetes Mellitus							
Drug Abuse							
Eating Disorders							
Eczema, Hives Rash							
Eye Problem/Glaucoma							
Heart Disease/Murmur							
High/Low Blood Pressure							
High Cholesterol							
Kidney/Bladder Problem							
Lead Poisoning							
Liver Disease/Jaundice							
Lung Disease							
Mental Illness							
Osteoporosis							
Parkinson's Disease							
Peptic Ulcer Disease							
Phlebitis/Blood Clot							
Rheumatic Fever							
Seizures/Epilepsy							
Stroke							
Suicide Attempt							
Thyroid Disease							
Tuberculosis							
Venereal Disease							
Other: _____							

## SENIOR ADULT REVIEW OF SYSTEM QUESTIONNAIRE

Instructions: Please circle the symptoms below that you feel are affecting your health.

**General:** Fatigue, unexplained weight gain, unexplained weight loss, poor appetite, feeling too hot, feeling too cold, night sweats, hot flashes, frequent nosebleeds, feelings of depression, episodes of crying, feelings of guilt, serious thoughts of suicide, difficulty sleeping, anxiety.

**Skin:** Unexplained skin rashes, unexplained skin bruising, growths on the skin, sores that do not heal, changing in the color or size of moles, unexplained skin dryness.

**Eyes:** Difficulty seeing, double vision, draining eyes, itchy eyes, eye pain, glasses/contacts.

**Ears:** Hearing difficulty, ringing of ears, pain, vertigo, hearing aid.

**Eating and Speech:** Dry mouth, chronic bad taste, loss of the ability to taste or smell, mouth sores that last more than two weeks, sinus or allergy problems, can't understand spoken speech, can't express yourself through speech, swallowing problems, dentures.

**Respiratory:** Difficulty breathing or shortness of breath, sleeping on more than one pillow, waking up short of breath constantly coughing, constant sputum production, coughing up blood, wheezing in your chest.

**Heart:** Chest pains or pressure, palpitations, swelling in your feet or ankles, leg cramps when you walk, leg cramps, at rest, passing out spells, pacemaker.

**Gastrointestinal:** Appetite changes, frequent heartburn, abdominal pain, frequent nausea or vomiting, vomiting of blood, food intolerances, black or tarry stools, blood in the stool, diarrhea, change in stool shape or color, constipation on a regular basis, excessive gas, regular use of laxatives, loss of control of stool, indigestion, ostomy.

**Urinary Tract:** Pain with urination, difficulty urinating, dark urine, foul-smelling urine, unexpected loss of urine when you cough or sneeze.

**Reproduction for Females:** Menopause, problems with sexual functioning, vaginal bleeding, breast masses, breast tenderness.

**Reproduction for Males:** Problems with sexual function, testicular masses, testicular pain, penile discharge, prostate problems.

**Neurodevelopmental:** Frequent or severe headaches, dizziness or lightheadedness, seizures or convulsions, falls or loss of balance, coordination problems, memory problems, fainting, tingling or numbness of any arm or leg, weakness or loss of function in any body part.

**Musculoskeletal:** Joint aches, joint swelling, joint stiffness, muscular pain or weakness, back pain, trouble walking or standing, foot problems.

**Social:** Excessive alcohol/drug use, tobacco use, have you been hit/insulted/threatened/ slapped by anyone?

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Date

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Patient Signature