Geriatric Medicine Clinic
Foxit Hospital

New Patient Questionnaire

The following questionnaire has been designed to provide us with the information needed to better assess your health. Please take your time in answering each question and provide as much information as possible.

Your Information

Name: _____ Date of Birth: _____

Name of Person completing this Form: _____ Today's Date: Jul/16/2020

What are your current biggest concerns regarding your health? _____

_____

Tell Us About Yourself

How long have you been living in Toronto?	
How far did you study in school?	
What faith (if any) do you follow?	
What sort of work have you done?	
What are your current activities?	
Are you currently married or have a partner?	
Do you have any children? If so, how many and where are they located?	
What type of residence do you live in?	
Do you live with anyone else?	
Have any of your friends or relatives died recently?	
Are you having any financial difficulties?	
Please describe any CCAC (Home Care) or other community support services (i.e. meals on wheels, etc) you may be currently receiving.	

Patient Name: _____

Planning For The Future

	Yes	No	Comments
Have you appointed a durable power of attorney for healthcare or financial decisions?	☐	☐	
If you were unable to make your own healthcare or financial decisions, who would you trust to make these decisions on your behalf?	Name of Person: _____ Relationship: _____ Address: _____ Telephone: _____		
Have you established any advance directives with regards to cardiac resuscitation, mechanical ventilation, feeding tubes, or other medical interventions that your doctor should know about?	☐	☐	

Your Medical History

Have you had any of the following conditions?	Yes	No	Comments
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Heart Disease	☐	☐	
Stroke	☐	☐	
Memory Problems	☐	☐	
Chronic Obstructive Pulmonary Disease (COPD) or Asthma	☐	☐	
Kidney Disease	☐	☐	
Arthritis	☐	☐	
Osteoporosis/Broken Bones	☐	☐	
Cancer	☐	☐	
Eye Diseases (Glaucoma, Macular Degeneration or Cataracts)	☐	☐	
Other (please list)			

Patient Name: _____

List Any Surgeries You Have Ever Had

Type	Date	Hospital

Do You Have A History of Any Psychiatric or Mental Health Issues?

Type	Comments

List All Hospitalizations You Have Had Within The Last 5 Years

Type	Date	Hospital

List your Primary Care/Family Doctor and other Specialists You See

Name	Contact number	Address

Patient Name: _____

My Medications (Please list all current medications, over the counter drugs and vitamins/supplements you take)

Name	Dose	When Taken

***Please bring all bottles and blister packs of current medications, over the counter drugs and vitamins to your visit.**

Allergies (Please list any medication allergies you have)

Drug	Reaction

Patient Name: _____

Health Maintenance

	Date	Yes	No	Comments
Has your cholesterol been checked?		☐	☐	
Has your bone mineral density been measured?		☐	☐	
Have you had a sigmoidoscopy or colonoscopy?		☐	☐	
Has your stool been checked for blood?		☐	☐	
Vaccinations				
Do you take the annual flu shot?		☐	☐	
Have you received the pneumonia vaccine?		☐	☐	
When was your last tetanus shot?		☐	☐	
Have you been received the shingles/ zoster vaccine?		☐	☐	
Personal Habits				
Do you engage in any exercise?		☐	☐	
Do you follow a special diet?		☐	☐	
Do you drink any alcohol?		☐	☐	
Do you smoke?		☐	☐	
Did you ever smoke?		☐	☐	
For Women				
When was your last mammogram/breast examination?				
When was your last pelvic exam/pap smear?				
Have you ever taken hormones (i.e. estrogen)?		☐	☐	
For Men				
When was your last prostate exam?				

Patient Name: _____

Functional Assessment

	Yes	No	Comments
Have you recently had an eye exam?	☐	☐	
Do you wear glasses?	☐	☐	
Have you recently had a dental exam?	☐	☐	
Do you wear dentures?	☐	☐	
Have you recently had your hearing checked?	☐	☐	
Do you use hearing aids?	☐	☐	

Do You Have Problems With Any of the Following Activities?

	Yes	No	Comments
Getting out of bed or a chair	☐	☐	
Walking	☐	☐	
Incontinence (leakage of urine or feces)	☐	☐	
Bathing yourself	☐	☐	
Dressing yourself	☐	☐	
Feeding yourself	☐	☐	
Doing your own cooking	☐	☐	
Doing your own cleaning	☐	☐	
Taking your medications	☐	☐	
Using the telephone	☐	☐	
Driving a car	☐	☐	
Using public transportation	☐	☐	
Doing your own shopping	☐	☐	
Managing your own finances	☐	☐	

Family History (Please list any major medical conditions that run in your family)

Patient Name: _____

Do You Have Any of the Following Concerns?

	Yes	No	Comments
A recent change in weight?	☐	☐	
Any episodes of falling?	☐	☐	
Problems with dizziness?	☐	☐	
Feeling sad or depressed?	☐	☐	
Any trouble sleeping?	☐	☐	
Problems with your hearing?	☐	☐	
Problems with your vision?	☐	☐	
Problems with teeth/dentures?	☐	☐	
Chronic cough?	☐	☐	
Chest pain, discomfort or heaviness?	☐	☐	
Shortness of breath?	☐	☐	
Constipation, diarrhea or change in bowel habits?	☐	☐	
Any problems with passing urine, leakage, or trouble starting your stream?	☐	☐	
Any problems with sexual function?	☐	☐	
Do you have any other symptoms or health concerns, which have not been mentioned on this form?	☐	☐	

Thank you for completing this form. The information you have provided will assist in your assessment.

If you do not have access to a fax, please bring these documents with you to your first appointment.

Your first appointment has been scheduled on _____.