KAISER PERMANENTE®
Geriatric Evaluation and Management Clinic

Member: ___________________________
MRN: _______________________________

Geriatric Pre-Visit Questionnaire

Thank you for having this form completed before your visit. It will allow your doctor to perform the most complete evaluation possible when you arrive for your appointment. Your time and effort are much appreciated.

Referral Data

What is (are) the main reason(s) for coming to the clinic? (check all that apply):

☐ Frailty Evaluation ☐ Memory/Cognition problem

☐ Medication Management ☐ Other____________________________

General Outlook

Compared to other people of the same age, how is your health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Screening Questions

1. In the last year, have you lost more than 10 pounds unintentionally? ☐ Yes ☐ No

   Do you wear dentures? ☐ Yes ☐ No

2. How often in the last week did you feel that everything you did was an effort?

   ☐ less than 1 day ☐ 1 or 2 days ☐ 3 or 4 days ☐ most of the time

3. How often in the last week did you feel that you could not get going?

   ☐ less than 1 day ☐ 1 or 2 days ☐ 3 or 4 days ☐ most of the time

4. Over the last 6 months, memory is: ☐ Worsening ☐ Staying the same ☐ Getting better

Comments ____

5. Over the last 6 months, ability to make decisions is: ☐ Worsening ☐ Staying the same ☐ Getting better

Comments ____

6. Are you afraid of falling? ☐ Yes ☐ No
   Have you had any falls in the past year? ☐ Yes ☐ No
   Number of injuries because of falls in the last 12 months: _____________ Specify: ______________________

If yes, describe the circumstance surrounding the fall:

☐ Trip over something ☐ Loss of consciousness

☐ Lightheadedness or palpitations prior ☐ Able to get up by self

Do you use a walking aid? ☐ Yes ☐ No If yes, which ones? ☐ Cane ☐ Walker ☐ Wheelchair

7. Do you lose control of urine when you don't want to? ☐ Yes ☐ No Wear: ☐ Pads ☐ Adult Diapers

8. Do you have any problems with hearing? ☐ Yes ☐ No Date of last exam: _______________________

   If yes, do you wear hearing aids? ☐ Yes ☐ No

9. Do you have any problems with vision? ☐ Yes ☐ No Date of last exam: _________________________

   If yes, do you wear glasses? ☐ Yes ☐ No

Mood/Personality/Behavior

*In the **last 1 month**, have you noticed any of the following?*

	Frequently	Sometimes	Does not Apply
Personality change	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐
Socially withdrawn	☐	☐	☐
Less interest in doing things, hobbies, or activities	☐	☐	☐
Irritable or easily frustrated	☐	☐	☐
Rapid changes in mood	☐	☐	☐
Stressed out	☐	☐	☐
More stubborn, agitated, aggressive, or resistive to help	☐	☐	☐
Acting impulsively without consideration of consequences	☐	☐	☐
Delusions/false beliefs, i.e. believing that things that have happened haven't, people are stealing from him/her	☐	☐	☐
Hearing voices, seeing things, talking to people who are not there	☐	☐	☐
Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐
Feeling anxious, nervous, tense, or fearful	☐	☐	☐
Following or "shadowing" caregiver	☐	☐	☐
Hiding or hoarding things	☐	☐	☐
Inappropriate behavior in public	☐	☐	☐
Wandering	☐	☐	☐

Comments ____

Assessment of Stressors

*Have any of the following occurred during the **past year**?*

	Yes	No
Change in living situation	☐	☐
Change in financial situation	☐	☐
Change in health of family member	☐	☐

Comments ____

Functional Abilities

Task	Does Not Need Help: Needs NO assistance or supervision	Does Not Need Help: Has Difficulty but Can Do by Self	Needs Assistance or Supervision	Totally Dependent: Cannot Do at All	Never Did: Baseline	If Help Needed, Who Helps?
Feeding self	☐	☐	☐	☐	☐	
Getting from bed to chair	☐	☐	☐	☐	☐	
Getting to toilet/continence	☐	☐	☐	☐	☐	
Getting dressed	☐	☐	☐	☐	☐	
Bathing or showering	☐	☐	☐	☐	☐	
Walking across the room (includes using cane or walker)	☐	☐	☐	☐	☐	
Writing checks, paying bills, or keeping financial records	☐	☐	☐	☐	☐	
Assembling tax records, business affairs, or papers	☐	☐	☐	☐	☐	
Shopping alone for clothes, household necessities, or groceries	☐	☐	☐	☐	☐	
Playing a game of skill or working on hobby	☐	☐	☐	☐	☐	
Heating water, making a cup of coffee, or turning off the stove	☐	☐	☐	☐	☐	
Preparing a meal	☐	☐	☐	☐	☐	
Keeping track of current events	☐	☐	☐	☐	☐	
Paying attention to, understanding or discussing a tv program, book, or magazine	☐	☐	☐	☐	☐	
Remembering appointments, family occasions, holidays, or medications	☐	☐	☐	☐	☐	
Travelling out of the neighborhood, driving, or arranging to take buses	☐	☐	☐	☐	☐	
Doing laundry	☐	☐	☐	☐	☐	
Using Telephone	☐	☐	☐	☐	☐	
Housekeeping	☐	☐	☐	☐	☐	

Social Function

Has there been a decline in social functioning?

☐ Changes in participation in church or community functions
☐ Conversing with friends and acquaintances in inappropriate manner
☐ Changes in participation in family celebrations and holidays
☐ Changes in participation in hobbies

Activities/Interests

Select the activities in which you regularly participate:

☐ Gardening ☐ Exercise ☐ Shopping ☐ Cooking ☐ Card Club ☐ Dining out
☐ Reading ☐ Pets ☐ Dancing ☐ Travel ☐ Music ☐ Church
☐ Others: ____

Driving

Are you currently driving? ☐ Yes ☐ No, stopped driving ☐ No, never drove
If driving, do you have concerns about driving? ☐ Yes ☐ No

If stopped driving, in what year did you stop driving? _______ Still has driver's license? ☐ Yes ☐ No

Alcohol and other Substances

How much alcohol do you drink? _____________ What type of alcohol (wine, vodka, etc)? _______________
Any history of alcohol withdrawal? ☐ Yes ☐ No
In the last 6 months, have you used any cannabis products? ☐ Yes ☐ No
If so, what type? ____

Have you taken any other substance in the past: ☐ Cocaine ☐ Methamphetamine Other: ___________

Do you currently smoke cigarettes? ☐ Yes ☐ No

Planning for Future Health Care

Do you have a Health Care Representative/Durable Power of Attorney for Healthcare? ☐ Yes ☐ No
Advanced Directives, POLST, or Living Will Completed? ☐ Yes ☐ No

If yes, please submit a copy with this form.

Who should be called if you are sick and need help? Please place an asterisk (*) next to the name of the person who is designated to be the health care representative or durable power of attorney for healthcare.

Name	Relationship	Phone Number
______________________	________________	(____) ____ — ________
______________________	________________	(____) ____ — ________
______________________	________________	(____) ____ — ________

Do we have permission to speak to the person(s) listed above on your behalf? ☐ Yes ☐ No

Goals of Care

What are your greatest fears about your health? ____

What are your hopes for the future about your health? ____

What is important to you in the time you have left? ____

Current Medications

Do you take 5 or more different prescription medications on a regular basis? ☐ Yes ☐ No
At times, do you forget to take your medications? ☐ Yes ☐ No

Please review the medication list given to you and compare it to the medications that the you actually take at home. Make any corrections if needed. Please add any other medications, including herbal/alternative medications, multi-vitamins, or any other over-the-counter medications being taken:

Name	Dosage	How Often?
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___

Family History

Do you have any family members with any of the following conditions?

Condition	Which Family Member?	Age of Onset
☐ Dementia or Alzheimer's Disease	___	___
☐ Heart Disease	___	___
☐ Stroke	___	___
☐ Parkinson's Disease	___	___
☐ Cancer	___	___

Other medical or psychiatric problems that run in the family: ______________________

Social History

Native Language: ______________________ Needs an Interpreter? ☐ Yes ☐ No

Education

☐ Less than 8th grade ☐ Some high school ☐ High school graduate
☐ Some college ☐ College graduate ______________ ☐ Graduate school ______________

Work Status

☐ Retired year, ________ Age: _____ ☐ Working part-time ☐ Working full-time

List principal occupation and other prior significant past occupations: ________________________________

____

Marital Status

☐ Never married ☐ Married; How many years? ______ ☐ Separated
☐ Divorced ☐ Widowed; How many years? ______

How many children do you have? ____ Are they in regular contact with you? ☐ Yes ☐ No

Living Arrangements

☐ Single-family house ☐ Condo ☐ Apartment
☐ Board and Care: ______________________________ Memory Care: ___________________________________
☐ Independent Living Facility: _____________________ ☐ Assisted Living Facility: __________________________
☐ Other (specify): ____

How many years at present location? ______

Check any of the following individuals that are living in the home with you:
☐ Spouse /Partner ☐ Son ☐ Son-in-law ☐ Daughter
☐ Daughter-in-law ☐ Other relatives ☐ Friend ☐ Other: ______________________

Are there steps into the home? ☐ Yes ☐ No

Are you receiving assistance or services at home? ☐ Yes ☐ No

If yes, please specify the type of assistance or services below:
☐ Home-delivered meals ☐ Adult day care ☐ Hospice ☐ Registered Nurse
☐ Home Health Care ☐ Home Health Aide ☐ Physical Therapist ☐ Occupational Therapist
☐ Social Worker ☐ Relatives & Friends ☐ Other Service ________________________________

If someone is helping you at home, how many hours per day and per week? ______________________________
____

Is the care being provided enough to meet your needs? ☐ Yes ☐ No

Any financial concerns? ☐ Yes ☐ No
Are you a veteran? ☐ Yes ☐ No
Are you a widow of a veteran? ☐ Yes ☐ No
Do you have long term care insurance? ☐ Yes ☐ No

Safety

Do you own any firearms? ☐ Yes ☐ No
If yes, are the firearms in the home? ☐ Yes ☐ No
Do you own any hunting knives? ☐ Yes ☐ No
If yes, are the hunting knives in the home? ☐ Yes ☐ No