# Patient Information Form

(Please Complete the Information below)

1. **Name :** _____
   SURNAME FIRST NAME

2. **D.O.B :** _____ **Health Card No.** _____-_____-_____ **Sex:** Male / Female
   Month / Day / Year

3. **Postal Address :** _____

   **City:** _____ **Postal Code :** _____ **Province :** _____

   **Telephone No. :** Home _____ Cell : _____

4. **E-Mail Address :** _____

   Preferred Method of Contact : _____Post _____ E-mail

5. **Next of kin:** Name _____

   Relationship : _____

   Tel. No. Home : _____ Cell : _____

6. **Family Doctor:** Name_____

   Address: _____

   Telephone No. : _____ Fax No. _____

7. **Pharmacy Information :** Name _____

   Address: _____

   Telephone No. : _____ Fax No. _____

# MEDICATIONS

List all medications including over the counter medications OR ask your pharmacist for a current list and attach it to this Form.

| Name | Dose | Frequency |
|---|---|---|
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# MEDICAL HISTORY SHEET

**A. Allergies:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

**B. History of Medical Problems : (both past and present – Tick all that apply)**

___ Hypertension
___ Diabetes Mellitus
___ Asthma
___ Arthritis
___ Osteoporosis
___ Congestive heart failure
___ Stroke
___ Atrial Fibrillation
___ Renal failure
___ Head Injury
___ Alcohol Problems
___ Gastroeosophageal reflux disease
___ Peptic Ulcer disease
___ Hearing problems
___Significant visual problems – please explain
_____
___ Chronic Obstructive Pulmonary disease
___ Depression
___ Anxiety
___ Hypothyroidism
___ Dementia
___ Transient Ischemic attacks

___ Others not listed above (please list) _____

_____

**C. Surgical History (Tick all that apply) :**

____ Hip surgery ____ left ____ right ____ Pacemaker insertion

____ Knee surgery ____ left ____ right

Surgery for the removal of : ____ tonsils ____ appendix ____ gallbladder

Others _____

_____

# FAMILY AND SOCIAL HISTORY

(Please write unknown if information requested is not known)

1. **Place of birth** _____

2. **Father's Occupation**

   _____

   Age at death _____

   Cause of death _____

3. **Mother's Occupation**

   _____

   Age at death _____

   Cause of death _____

4. **Childhood:** ____ Happy ____ Unhappy

   If unhappy please explain briefly _____

   _____

   _____

   _____

5. **Highest level of education**

   _____

6. **Number of Siblings**

   _____

   No. of Brothers _____ No. of Sisters _____

   Number of siblings deceased and cause of death _____

   _____

   _____

7. **Family History of Mental Health problems** ____ Yes ____ No
   Family History of Dementia ____ Yes ____ No

   If yes, give relationship and diagnosis _____

   _____

   _____

8. **Occupation** _____

9. **Marital Status :** ____ Married ____ Never Married ____ Widowed

   ____ Separated ____ Divorced

10. **Spouse's occupation** _____

Circle if spouse is : Alive Deceased

Age at death (if deceased) _____ Year (if known) _____

Cause of death _____

11. **Total number of Children** _____

No. of Sons _____ City of Residence _____

_____

No of Daughters _____ City of Residence _____

_____

12. **Current place Residence :**

____ Own private home ____ Rented property

____ Care Home Duration of time in Care Home _____

____ Assisted Living Facility ____ Other

If other, please explain _____

_____

_____

13. **Financial Situation :** Any debit ____ Yes ____ No

If yes please explain _____

_____

_____

14. **Legal problems (Past and Present) :** ____ Yes ____ No

If yes, please explain _____

_____

_____

_____

_____

_____

_____

_____

# MEMORY SCREENING SHEET

( Please complete this with the help of a caregiver / friend / family member if possible)

Do you have any concerns about forgetfulness or your memory ? ____ Yes ____ No
If yes please answer the following questions below (tick all that apply) :
Length of time memory has been a concern _____

1. **Me:**
   ____ Forgetting conversations
   ____ Forgetting correct month or year
   ____ Leaving stove on
   ____ Repeating the same questions
   ____ Misplacing things
   ____ Forgetting recent events
   ____ Forgetting names of people

   Please explain briefly _____
   _____
   _____

2. **AG:**
   ____ Difficulty recognizing familiar objects or people

   Please explain briefly _____
   _____
   _____

3. **AP:**
   ____ Difficulty putting movements in sequence (e.g taking the necessary steps to make a cup of coffee, prepare meals) ?
   ____ Trouble using utensils to eat

   Please explain briefly _____
   _____
   _____

4. **LAN:**
   ____ Word-finding difficulties for people's names, common words
   ____ Difficulty understanding instructions

   Please explain briefly _____
   _____
   _____

5. **C & D :**
   ____ Getting lost in familiar surroundings
   ____ Trouble finding your way when driving

   Please explain briefly _____
   _____

6. **EF:**

Problems / difficulties with:

____ Bathing and grooming ____ Shopping

____ Dressing appropriately ____ Using the telephone

____ Going out alone ____ Handling finances

Please explain briefly _____

_____

_____

7. **P & B:**

( tick any changes in personality and or behavior noted)

____ Seeing or hearing things that other people do not

____ Being suspicious of others like believing people are out to harm you

____ Verbal aggression

____ Physical aggression

____ Agitation

____ Being socially inappropriate, acting out of character or exhibiting poor judgment

____ Problems with disruptive behavior

____ Problems with wandering

____ Incontinence problems ____ Urine ____ fecal ____ both

Please explain briefly _____

_____

_____

8. **Caregiver (Please complete this section) :**

Level of frustration / worry ____ Low ____ Average ____ High

Level of feelings of isolation ____ Low ____ Average ____ High

Level of stress ____ Low ____ Average ____ High

Please comment briefly _____

_____

_____

**9. Any other relevant comments and information:**

## GERIATRIC DEPRESSION SCALE

**Patient Name : _____ Date: _____**

Circle the answers that best describe how you have felt over the **past-week**:

| | | | |
|---|---|---|---|
| 1 | Are you basically satisfied with your life ? | **YES** | **NO** |
| 2 | Are you in good spirits most of the time ? | **YES** | **NO** |
| 3 | Do you think it is wonderful to be alive now ? | **YES** | **NO** |
| 4 | Do you feel full of energy ? | **YES** | **NO** |
| 5 | Do you feel happy most of the time ? | **YES** | **NO** |
| 6 | Do you have dropped many of your activities and interests ? | **YES** | **NO** |
| 7 | Do you feel that your life is empty ? | **YES** | **NO** |
| 8 | Do you often feel bored ? | **YES** | **NO** |
| 9 | Are you afraid that something bad is going to happen to you ? | **YES** | **NO** |
| 10 | Do you feel helpless ? | **YES** | **NO** |
| 11 | Do you prefer to stay home rather than going out and doing things ? | **YES** | **NO** |
| 12 | Do you feel you have more problems with your memory than most people ? | **YES** | **NO** |
| 13 | Do you feel pretty worthless the way you are right now ? | **YES** | **NO** |
| 14 | Do you feel your situation is hopeless ? | **YES** | **NO** |
| 15 | Do you think that most people are better off than you ? | **YES** | **NO** |

| | |
|---|---|
| **Total Score :** | /15 |

## GAD - 7

Over the **last two weeks** how often have you been bothered by the following problems ?
Use a circle to indicate your answer.

| | | **Not at all** | **Several Days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|---|
| 1 | Feeling nervous, anxious, or on edge. | 0 | 1 | 2 | 3 |
| 2 | Not being able to stop or control worrying. | 0 | 1 | 2 | 3 |
| 3 | Worrying too much about different things. | 0 | 1 | 2 | 3 |
| 4 | Trouble relaxing. | 0 | 1 | 2 | 3 |
| 5 | Being so restless that is hard to sit still. | 0 | 1 | 2 | 3 |
| 6 | Becoming easily annoyed or irritable. | 0 | 1 | 2 | 3 |
| 7 | Feeling afraid as if something awful might happen. | 0 | 1 | 2 | 3 |
| | **GAD-7 Total Score :** (add columns _____**/21**) **=** | | | | |

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people ?

| **Not difficult at all** | **Somewhat difficult** | **Very difficult** | **Extremely difficult** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |