Geriatric Medical History Checklist

Patient Information

Name:

Date of Birth:

Age:

Gender:

Medical History

- [ ] Hypertension
- [ ] Diabetes Mellitus
- [ ] Heart Disease
- [ ] History of Stroke
- [ ] Chronic Lung Disease (e.g. COPD, Asthma)
- [ ] Chronic Kidney Disease
- [ ] Chronic Liver Disease
- [ ] History of Cancer
- [ ] Dementia / Memory Problems
- [ ] Depression / Anxiety
- [ ] Other (specify below)

Details:

Medication History

List current medications, dosages, and supplements

Functional Assessment

- [ ] Needs assistance with Activities of Daily Living (ADL)
- [ ] History of falls in the past year
- [ ] Hearing impairment
- [ ] Vision impairment
- [ ] Urinary/Bowel Incontinence

Allergies

List allergies (medication, food, other)

Social History

- [ ] Current or past smoker
- [ ] Alcohol use
- [ ] Lives alone
- [ ] Has caregiver/support

Other Details:

Advance Directives / End-of-Life Planning

- [ ] Advance Directive in place
- [ ] Power of Attorney for Health Care

Other comments