OhioHealth

JOHN J. GERLACH CENTER FOR SENIOR HEALTH
GERIATRIC ASSESSMENT QUESTIONNAIRE

PATIENT NAME (Last, First, Middle Initial)				Primary Insurance	ID #
Address				Secondary Insurance	ID #
City	State	Zip Code	County	E-mail	
Home Phone	Cell Phone			OK to leave a message? Home Work Cell	
Date of Birth	Social Security Number	Age	Sex	Gender Identity (optional):	Sexual Orientation (optional):

Correct Pronouns (optional): ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other:

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐Hispanic ☐Other
Primary language: _____

NAME OF SUPPORT PERSON (Accompanying Patient to Appointment)				Relationship	
Address				E-mail	
City	State	Zip Code	Primary Phone # Home Work Cell	Secondary Phone # Home Work Cell	
PERSON/AGENCY WHO SCHEDULES APPOINTMENTS (if applicable)				Primary Phone Number:	
NAME OF FAMILY DOCTOR (PRIMARY CARE PROVIDER)				Office Phone	
NAME OF NEUROLOGIST (if applicable)				Office Phone	
NAME OF NEUROPSYCHOLOGIST (if applicable)				Office Phone	
NAME OF PSYCHIATRIST (if applicable)				Office Phone	

REASON(S) FOR YOUR VISIT TO GERLACH CENTER (HOW CAN WE HELP?)

_____

_____

_____

_____

CURRENT STATUS

☐Married

____ Number of Marriages

☐Widowed

☐Divorced

☐Separated

☐Single (never married)

☐Partnered with significant other

ADULT CHILDREN ____ Number

SUPPORT

☐Live Alone

☐Live with:

_____
(RELATIONSHIP)

_____
(NAME)

HOME

☐One-story home

☐Two-story home

☐Apartment

☐Retirement Community

☐Independent

☐Assisted Living

☐Nursing Home

ADVANCE DIRECTIVES *(Please bring copies of health/mental health related documents to your appointment.)*

☐Healthcare Durable Power of Attorney_____
(NAME)

☐Living Will _____
(NAME)

☐Declaration for Mental Health Treatment_____
(NAME)

☐Financial Durable Power of Attorney_____
(NAME)

☐Court Appointed Guardian_____/_____
(NAME) (PHONE)

HIGHEST LEVEL OF EDUCATION (please circle)

Grade School

1 2 3 4 5 6 7 8 9 10 11 12

College

1 2 3 4

Advance Degree

Title _____

MILITARY SERVICE

☐Veteran ☐Spouse of Veteran Branch of Service: _____

EMPLOYMENT

☐Currently Employed ☐Semi-Retired ☐Retired ☐Self-Employed

Place of Retirement From: _____ Retirement Year: _____

What type of work have you done in your life? How many years?

_____

DAILY ACTIVITIES	INDEPENDENT	NEEDS HELP	UNABLE
Toileting	☐	☐	☐
Bathing	☐	☐	☐
Eating	☐	☐	☐
Dressing	☐	☐	☐
Brushing Teeth/Dentures	☐	☐	☐
Finances/Paying Bills	☐	☐	☐
Cooking	☐	☐	☐
Grocery Shopping	☐	☐	☐
Housework/Laundry	☐	☐	☐
Using the Telephone	☐	☐	☐
Managing Medications	☐	☐	☐

DRIVING

Are you currently driving? ☐Yes ☐No
Any driving accidents in the last year? ☐Yes ☐No
Any driving citations in the last year? ☐Yes ☐No

SMOKING HISTORY:

☐Never Smoked ☐Currently Smoking/Packs per day: ___ ☐Quit Smoking/Year: ___
☐Cigar ☐Pipe ☐Chew Tobacco

ALCOHOL HISTORY: Do you drink alcohol? ☐Yes ☐No
If yes, how much alcohol do you drink? _____

COMMUNITY SERVICES/MEDICAL EQUIPMENT (currently using)

☐Meals on Wheels
☐Transportation
☐Home Health Nurse
☐Physical/Occupational/Speech Therapy
☐Homemaker
☐Senior Options_____ (CASE MANAGER)
☐Personal Care Aid/Home Health Aid
☐Emergency Response System
☐Home Medical Equipment
☐Adult Day Care
☐Passport (Medicaid Waiver)_____ (CASE MANAGER)
☐Veteran Services

Service Provider: _____ (NAME) / _____ (PHONE)
Medical Equipment (cane, walker, wheelchair, etc.): _____
Do you wear dentures: ☐Yes ☐No
Do you wear hearing aids: ☐Yes ☐No
Do you wear glasses: ☐Yes ☐No
Are you legally blind? ☐Yes ☐No

FORM COMPLETED BY:

_____ (NAME/RELATIONSHIP) _____ (DATE COMPLETED)

How did you hear about us? _____