Carolina Aponte Urdaneta, MD, LLC.
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Tel: 913-608-9482
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Geriatric New Patient Questionnaire

DEMOGRAPHIC INFORMATION: Today's Date: _____/_____/_____

Name: _____
First Middle Last

Age: _____ **Date of Birth:** _____/_____/_____

Gender: M F **Marital Status:** Single Married Separated Divorced Widowed

Ethnicity (Optional- circle all that apply):
African American American Indian Asian/ Pacific Islander Caucasian
Hispanic Multiracial Other: _____

Religion (Optional): _____

Home Address: _____

Home: (_____) _____-_____ **Cell:** (_____) _____-_____ **Fax:** (_____) _____-_____

Email: _____

Employer's Name: _____ **Phone:** (_____) _____-_____

Job Title: _____ **Preferred Way To Reach You:** _____

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Where were you born? _____

Primary Language(s): _____

Preferred Language: _____

How long have you lived in the Kansas City Metro Area? _____

Emergency Contact:

Name: _____ Relationship: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____

Reason for Referral:

Who referred you to this office? _____

What are the problems for which you are seeking help? _____

_____

Why seek help now? _____

What goal(s) do you expect psychiatric treatment will help you achieve? _____

How long do you expect this treatment to take? _____

What kind of treatment do you expect? (Talk therapy, medication, both, other): _____

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MEDICAL HISTORY:

Have you ever suffered from any of the following conditions? (Circle all that apply):

Neurological:	Frequent falls, Seizures, Frequent headaches, Tics, Dystonias, Parkinson's disease, Dementia, Delirium, Stroke, Multiple Sclerosis, Encephalitis, Meningitis
Head:	Blurry Vision, Dizziness, Seasonal Allergies, Hearing loss, Frequent sinus infections
Heart:	Hypertension, Arrhythmias, Frequent shortness of breath, Palpitations, Frequent chest pain, Heart failure, Heart murmur, Mitral valve prolapse, Endocarditis, Heart attack, Swollen legs
Lungs:	Asthma, Obstructive Sleep Apnea (OSA), Chronic cough, Emphysema, Chronic Bronchitis, Sarcoidosis, Tuberculosis (TB)
Gastrointestinal:	Reflux disease (GERD), Frequent heartburn, Ulcers, Chronic diarrhea or constipation, Frequent stomachaches, Irritable bowel syndrome (IBS), Crohn's disease, Ulcerative Colitis, Celiac disease, Pancreatitis, Liver disease, Gallbladder disease
Urinary:	Benign prostatic hypertrophy (BPH), Frequent blood in urine, Kidney failure, Urinary tract infections (UTI), Kidney infections, Kidney stones, Sexually transmitted disease (STD), Sexual dysfunction, Premenstrual syndrome (PMS), Premenstrual dysphoric disorder (PMDD), Polycystic ovary syndrome (PCOS), Infertility
Musculoskeletal:	Chronic back pain, Fibromyalgia, Chronic joint pain, Arthritis, Gout, Osteoporosis, A significant bone fracture
Skin:	Eczema, Severe or persistent rash, Psoriasis, Bed sores, Cellulitis
Immunologic:	Cancer, HIV, Hepatitis B, Hepatitis C, Lupus, Lyme disease
Endocrine:	Diabetes, Hypothyroidism, Hyperthyroidism, Elevated Cholesterol, Elevated Triglycerides, Obesity

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Do you suffer from any other chronic illness not listed above? (Please list): _____

_____

Who is your current Primary Care Physician? _____

Date of your last physical exam? _____

SURGICAL HISTORY: (Please list all surgeries with approximate dates)

_____

_____

Accidents:

Have you ever sustained any significant head injury? Y N

When did the head injury (ies) occur? _____

How did the head injury (ies) happen? _____

Did you loose consciousness? Y N For how long? _____

CURRENT MEDICATIONS: (Please include all prescription drugs as well as over the counter medications, vitamins and supplements – Use the back of this page if needed)

Name	Indication	Dosage	Duration of Treatment	Side Effects

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ALLERGIES: _____

PAST MENTAL HEALTH HISTORY:

Have you ever received psychiatric treatment? Y N

If yes, please describe any intervention you have previously received: _____

Please list prior diagnoses: _____

Please indicate if you have received any of the following treatments and their effectiveness:

Type of Therapy	Level of Improvement with Therapy		
Psychodynamic Psychotherapy	A lot	Some	None
Psychoanalysis	A lot	Some	None
Cognitive Behavioral Therapy (CBT)	A lot	Some	None
Dialectical Behavior Therapy (DBT)	A lot	Some	None
Interpersonal Therapy (IPT)	A lot	Some	None
Family/ Couples Therapy	A lot	Some	None
Other _____	A lot	Some	None

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Have you ever been hospitalized for a psychiatric condition? Y N

If yes, please specify dates and circumstances:

Name of Institution where admitted	Approximate dates	Circumstances that lead to hospitalization

Please list, to the best of your recollection, any and all psychiatric medications you have ever taken (Use the back of this paper if necessary):

Name	Indication	Dosage	Duration of Treatment	Side Effects

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FAMILY HISTORY: (Please list any blood relatives who currently struggle with or have been treated for any mental illness and/ or psychological, emotional or behavioral difficulties, or problems with use or abuse of substances such as alcohol or drugs.)

Relationship to You	List of Disorders

Do medical illnesses run in your family? (E.g. seizures, thyroid problems, etc.) Y N

If yes, please list the illness and the family members that suffer from this illness: _____

_____

_____

SOCIAL HISTORY AND PERSONAL HABITS:

Have you ever served in the Armed Forces, active duty or reserve? Y N

Have you ever experienced or witnessed a traumatic event such as combat, rape, sexual abuse, physical abuse, or any other extremely upsetting incident? Y N

How many cups, glasses, or cans of caffeinated products do you drink per day? _____

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How many glasses, cans, or bottles of alcoholic beverages do you drink per month on average?

Between 1- 3 Between 3- 10 Between 10- 20

Between 20- 40 More than 40

Have you ever tried to cut down your use of alcohol? Y N

Have you ever felt guilty about using alcohol? Y N

How often do you gamble? (Sports betting, racetrack, cards, casino, etc.): _____

Do you smoke? Y N If yes, how much do you smoke per week? _____

Have you ever overused/ abused any street drugs, prescription drugs or over the counter medications? Y N

If yes, please explain: _____

Have you ever used anabolic steroids? Y N

Is anyone that you are in a close relationship with abusing drugs and/or alcohol? Y N

What activities do you engage in regularly for fun? _____

Do you exercise regularly? Y N How frequently? _____

What do you typically do to de-stress? _____

Please describe your sleep (circle all that apply):

Excessive Restless Restful Poor Difficulties initiating sleep

Nighttime awakenings No difficulties

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Home Environment: (Please list every member of your household)

Name	Relationship to You	Age	Living at Home: Y or N

Do you have children? Y N If so, how many? _____

If divorced, who has custody? Mother Father Joint custody

Neither- please specify: _____

Are any of your children adopted? Y N

If yes, please describe the circumstances of the adoption: _____

_____

Have you lost a child? Y N

Do any of your children have special needs? Y N

If so, please describe: _____

Do you have a history of violence in your house or in your relationships? Y N

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Legal History:

Have you ever been convicted of a crime? Y N

Have you ever assaulted anyone? Y N

Have you ever been investigated by the Department of Social Services (DSS) or the Department of Child and Family Services (DCFS)? Y N

Are you currently involved in any legal case(s)? Y N

Have you ever applied for a gun permit? Y N

Do you currently own a gun? Y N

Education:

Please circle the highest level of education achieved:

Some High School High School Diploma Some Undergraduate College

Technical Training Associate Degree Bachelor's Degree Master's Degree

Doctorate Professional Degree (MD, JD, DMD)

Name of institution you currently attend/ you last attended: _____

Date you graduated/ expect to graduate: _____

How do you rate your performance at the institution mentioned above?

Poor Fair Good Other _____

Do you have any learning disabilities or attention problems? Y N

If yes, please explain your specific disabilities and indicate when you were diagnosed: _____

_____

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Work:

Are you currently employed? Y N Occupation: _____

How long have you been with your current employer? _____

How would you describe your current level of job satisfaction?

Very satisfied Satisfied Average Dissatisfied Very dissatisfied

If you are not currently employed, which of the following describes you? (check all that apply)

Retired Stay at home parent Looking for work

Student Caring for sick / elderly relative Other

ACTIVITIES OF DAILY LIVING

Do you need help or do you have any difficulties doing the following activities (please circle any that apply):

Cooking BathingDressing Going to the bathroom

Balancing your checkbook Paying Bills

MEMORY (please explain briefly your answers)

Have you noticed difficulty holding new information? _____

_____

Have you found yourself being forgetful of appointments? _____

_____

Do people notice any problems with your memory? _____

_____

Do you recognize peoples faces? _____

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Do you have trouble putting names and faces together? _____

Did this symptoms started suddenly or is it hard to pinpoint? _____

Do your problems with memory influence the way you interact with other people? _____

_____

Have you found you loose your train of thought? _____

_____

Any changes in your reading? _____

Any changes in your ability to understand spoken language? _____

Any changes in your everyday activities? _____

_____

Any changes in your math abilities? _____

_____

Have you had trouble getting turned around or have you found yourself getting lost?

_____

_____

Any changes in the way you make decisions? _____

_____

Any stumbling while walking? _____

_____

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Any episodes where you thought you were having a stroke? _____

_____

Have you isolated from people? _____

Any changes in your handwriting? _____

Any changes in your sense of smell? _____

How is your vision/ hearing? _____

_____

Any tendency to ruminate about things in the past? _____

_____

Any difficulties with word finding or changes in speech? _____

_____

OTHER: Please share any additional information or concerns that you think may be relevant for your initial visit.

_____

_____

_____

_____

_____

_____