Geriatric Medical History Form

Personal Information

Full Name

Date of Birth

Gender

Contact Number

Address

Emergency Contact Name & Number

Medical History

Current Medications

Allergies (medications, food, etc.)

Chronic Conditions (e.g. diabetes, hypertension)

Previous Surgeries or Hospitalizations

Family Medical History

Immunization Status

Functional Assessment

Any difficulties with Activities of Daily Living?

Mobility Issues

Vision or Hearing Problems

Use of Assistive Devices (e.g. walker, hearing aid)

Lifestyle & Other Information

Diet

Exercise & Physical Activity

Tobacco/Alcohol Use

Additional Notes/Comments