OCEAN FAMILY & GERIATRIC ASSOCIATES

MEDICAL INFORMATION

Patient Name: **My Occupation**: **Date:** - - 2024

Please answer all questions below:

IMMUNIZATION:

COVID-19 vaccine	NEVER; Moderna Pfizer J&J Did you have COVID infection? Yes No		1st shot 2nd shot 1st 2nd 3rd booster
Influenza vaccine	NEVER		Last Flu shot in: 2021 2022
Shingles vaccine	NEVER	Recommended age 50+ years	1st dose 2nd dose Last dose ____ years ago
Pneumonia vaccine	NEVER	Recommended 1st dose between 19 yrs. and 64 years, 2nd dose at 65 plus years	1st dose 2nd dose Last dose ____ years ago
Tetanus (TDaP)	NEVER	Recommended booster <u>every 10 years</u>	Last booster ____ years ago

DIAGNOSTIC TESTING:

Colonoscopy	Never	_____ years ago	List ALL other DOCTORS you are seeing:
Mammogram (women only)	Never	_____ years ago	1.
Pap Smear (women only)	Never	_____ years ago	2.
Electrocardiogram (EKG)	Never	_____ years ago	3.
Cardiac Stress Test: Treadmill or Nuclear	Never	_____ years ago	List ALL new medications/vitamins:
Chest XR	Never	_____ years ago	1.
Pulmonary Function Test (PFT)	Never	_____ years ago	2.
Carotid Doppler for blockage	Never	_____ years ago	3.
DEXA bone scan for Osteoporosis screening	Never	_____ years ago	4.
Abdominal Aortic Aneurysm Screening ultrasound scan	Never	_____ years ago	5.
Prostate screening blood test (PSA) (men only)	Never	_____ years ago	6.
Any CT Scan? When:	Reason:		
Any MRI Scan? When:	Reason:		
Any Ultrasound Scan? When:	Reason:		
Any Hospitalization in last 1 year? Yes No	Reason:		

SCREENINGS:

<u>Insomnia:</u> *Do you experience any sleep issues:* difficulty falling or staying asleep waking up and difficulty going back to sleep waking up very early in morning snoring restless sleep nightmares racing thoughts while trying to sleep unusual movement while asleep

Depression: *In last 30 days have experienced any symptoms of depression*: feeling of emptiness or sadness reduced interest in activities lack of energy/constant fatigue irritability pain or other physical changes loss of appetite sleep issues lack of concentration slow thinking thought of death or suicide alcohol or drug abuse

Dementia: *Have you, your family or friends noticed any memory issues*: experiencing word block forgetting things often struggling to retain new information difficulty performing familiar tasks disorientation to place (e.g., Where you parked your car in parking lot) misplacing things loss of interest in family, friends, or favorite activities confusion feel sad, moody, angry, or teary eyes for no apparent reason

Alcohol: *Do you regularly drink alcohol*? Use alcohol on social occasions? How often do you drink alcohol? _____X per day/week?
Tobacco Use: *Do you smoke cigarettes, cigars, or vape?* How often? /day; How long? When did you quit?
Vision change: *Do you have any vision issues?* Yes No Do you use contact/glasses? Reading, distance, bifocal, progressives?
Last Eye Exam: _____ Last Hearing Exam: _____
Hearing change: *Do you have any hearing issues?* Yes No What percent hearing loss? Do you use a hearing aid? Yes No
How would you describe your current overall health: "_____"