Mass General Brigham

Cooley Dickinson Geriatrics
22 Atwood Drive Suite 201
Northampton MA 01060
Tel 413-585-0755

New Patient Information Form

Name: _____ **Date of Birth:** _____
Preferred Name: _____ **Language Preferred:** _____
Primary Care Provider: _____ **Phone Number:** _____
Pharmacy Name and Location: _____
Who referred you to us? _____
Who should we contact for follow up appointments?
Name: _____ Phone: _____
Why are you coming to see us? _____
_____
What are your goals for this visit? _____
_____
Do you have any particular concerns that you would like us to know about?
_____
_____
Have you been in the hospital in the last 6 months? If yes-why and when?
_____
_____

General Information about You

Where were you Born/raised? _____Where do you live now? _____
□ Home/Apartment/Condo □ Independent/Over 55 Community □ Assisted Living
□ Other_____
With whom do you live? □ Alone □ My Spouse/Partner □ Family □ Roommate/Friend
□ Other _____
Do you have help at home? □ Yes □ No How often? _____
What kind of help? □ Cleaning □ Chores □ Cooking/Meals □ Shopping □ Personal Care
□ Other _____
Do you provide care for a family member? □Yes □No If yes, who? _____
Do you have questions or concerns about driving or getting around? □ Yes □ No
Do you have concerns about your living situation?_____
_____
Do you use any or all of the following? □ Cane □ Walker □ Wheelchair
Have you fallen in the past year? □ Yes □ No How many times? _____ When? _____
Were you injured? □ Yes □ No Are you afraid of falling? □ Yes □ No
How well do you sleep most of the time? □ Very Well □ Mostly ok □ Poorly □ Too Much □ Too Little
Do you Snore □ Yes □ No □ I don't know
Have you been tested for Sleep Apnea? □ Yes □ No □ I don't know

Name_____ Date of Birth_____

How is your appetite most of the time? □ Good □ Fair □ Poor
Are you eating less or more than usual in the last 3 months? □ Less □ More
Has your weight changed in the last year?
□ Increase □ Decrease □ No change □ I don't know
Do you prepare your own meals? □ Yes □ No
Would you like more information about nutrition or any assistance with meals? □ Yes □No
Do you have any financial concerns? □ Yes □ No □ I'm not sure
Do you exercise? □ Yes □ No
How often? □ Daily □ 3-5 times/week □ Less than 3 days/week
What kind of exercise do you do? _____
Are you worried about your health? If so, what?
_____
_____

General Independence and Health Maintenance

Do you need or have help with the following (check appropriate column)

	Fully Independent	I Need Some Assistance	I do not do this at all
□ Bathing			
□ Dressing			
□ Toileting			
□ Moving in and out of bed or chair			
□ Eating and or Drinking			
□ Driving			
□ Paying bills and managing finances			
□ Shopping			
□ Preparing food & housekeeping			
□ Laundry			
□ Taking Medications			

How does your health compare to most people of your age?	□ Better	□ Same	□ Not as good
Do you feel tired during the day?	□ Yes	□ No	□ Not Sure
Can you walk up a flight of stairs comfortably?	□ Yes	□ No	□ Not Sure
Can you walk around the block comfortably	□ Yes	□ No	□ Not Sure
Do you feel sad or depressed most days?	□ Yes	□ No	□ Not Sure
Do you feel worried or anxious?	□ Yes	□ No	□ Not Sure
Do have more memory problems than most people your age?	□ Yes	□ No	□ Not Sure
Are you or others concerned about your memory?	□ Yes	□ No	□ Not Sure
Have you had a hearing test within the last two years?	□ Yes	□ No	□ Not Sure
Have you had an eye exam within the past year?	□ Yes	□ No	□ Not Sure
Have you had any dental exam within the past year?	□ Yes	□ No	□ Not Sure

Name_____ Date of Birth_____

Medical History

EYE AND EAR
- □ Cataracts
- □ Glaucoma
- □ Macular degeneration
- □ Hearing loss / hearing aid

KIDNEY & URINARY
- □ Kidney disease
- □ Prostate disease
- □ Frequent urinary infections
- □ Urinary incontinence

LUNG
- □ Smoking
- □ Asthma
- □ COPD
- □ Bronchitis

NERVOUS SYSTEM
- □ Chronic Pain Where? _____
- □ Stroke / TIA When? _____
- □ Dementia / Alzheimer's Disease
- □ Parkinson's Disease

HEART
- □ Heart attack. When?_____
- □ Heart failure
- □ High blood pressure
- □ Irregular heart beat/ arrhythmia

BONE & JOINT
- □ Arthritis
- □ Osteoporosis □ Osteopenia
- □ Gout
- □ Fractured □ hip □ wrist □ spine □ other

GASTROINTESTINAL
- □ Ulcers
- □ Heartburn/Reflux
- □ Diverticulitis
- □ Liver disease / cirrhosis
- □ Hepatitis
- □ Polyps

OTHER HEALTH CONCERNS
- □ Anemia
- □ Hernia
- □ Blood Clot /Thrombosis
- □ Cancer Where?_____ When? _____
- □ Depression
- □ Reproductive/Genital or Sexual Health

GLANDULAR/ENDOCRINE/METABOLIC □ Diabetes □ Thyroid □ Other_____

OTHER HEALTH CONCERNS: _____

Hospital Admissions and/or Surgeries

DATE	REASON

Name_____ Date of Birth_____

Allergies

Medication	Food	Other

Medications: Bring a current list to the appointment

Name of medication	Dose	How many? How many times a day?

Social History

What is your preferred language? _____

Are you comfortable in your current home? □ Yes □ No-I dislike: _____

What is your level of education? □ High School/GED □ Licensed Trade □ Associate's Degree

□ Bachelor's Degree □ Master's Degree □ Advanced Degree □ Other _____

Employment □ Retired/Not Working □ Part-time Work □ Full-Time Work □Volunteer Work

What field of study or type of work? _____

Do you identify as: □ Male □ Female □ GenderQueer □ Other_____ □ Prefer not to answer

□ Heterosexual □ Gay/Lesbian □ Bisexual □ Queer □ Other _____□ Prefer not to answer

Are you: □ Married/Partnered □ Divorced/Separated □ Widowed □ Never Partnered or Married

Do you have children? If yes, how many? _____ □ Biological □ Adopted/Foster □ Step

Are you in regular contact with your children? □ Yes □ No

How often do you spend time with others? □ Daily □ 3-5 times weekly □ Less than 2 days weekly

Do you spend less or more time with others than usual? □ More time □ Less time □ No change

Name_____ Date of Birth_____

Alcohol, Tobacco, and other substances/drugs

Do you drink alcohol? How often?

□ Daily □ 4 or more days a week □up to 3 times a week □ Less than once a week □ Never

Has anyone ever been concerned about your drinking? □ Yes □No □ I don't know

Are you concerned about your alcohol intake? □ Yes □No □ I don't know

Do you smoke vape, or use tobacco now? □ Yes □ No How often/How much? _____

If you stopped: When? ____ How much did you smoke? _____ For how long? _____

Have you ever used marijuana, cocaine or IV drugs? What? _____

□ Yes □ No □ Stopped/Quit in ___ □ Currently use—if so, how often? _____

Thank you for taking the time to complete this form.
Please bring a close family member or friend to your appointment.
Please call us if you have any questions at 413-585-0755.

PLEASE RETURN THIS FORM TWO WEEKS BEFORE THE APPOINTMENT.
Return this form via The Patient Gateway, Mail, or Fax to:

Cooley Dickinson Geriatrics
22 Atwood Drive Suite 201
Northampton MA 01060
Fax 413-341-2261

To learn more about healthy aging, dementia, and sources of support
See the resources section of our website: https://www.cooleydickinson.org/programs-services/geriatrics/resources/