Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)
GERIATRIC PSYCHIATRIC QUESTIONNAIRE

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Date: _____

Best phone number to reach you: _____ - _____ - _____

Current residence: _____

Please list up to 3 relatives you would like to be involved in your care.

Name: _____ Relationship: _____

Phone number: _____ - _____ - _____

Name: _____ Relationship: _____

Phone number: _____ - _____ - _____

Name: _____ Relationship: _____

Phone number: _____ - _____ - _____

Please list your Health Care Power of Attorney, if you have one.

Name: _____

Phone number: _____ - _____ - _____

Please list all the doctors currently involved in your care, starting with your primary care doctor.

Name: _____

Clinic: _____

Phone number: _____ - _____ - _____

Name: _____

Clinic: _____

Phone number: _____ - _____ - _____

Name: _____

Clinic: _____

Phone number: _____ - _____ - _____

Name: _____

Clinic: _____

Phone number: _____ - _____ - _____

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Pharmacy name: _____

Pharmacy phone number: _____ - _____ - _____

Please list your current medications, including any over-the-counter remedies, vitamins and herbal products. Include the reason why you are taking each medication.

Medication	Dose	Schedule	Reason

List any medications you are allergic to, and what reactions you have had: _____

_____

Is there a history of blood related family member who have had mental illness (depression, bipolar disorder, schizophrenia, anxiety, etc.), substance abuse (Alcohol, marijuana, misuse of sleeping pills, etc.) or neurological illnesses (dementia, Alzheimer's disease, Parkinson's disease, multiple sclerosis, etc.)? If so, what is the relation to the patient and what illnesses are/were present?

_____

_____

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Please check any medical conditions you have:

- ☐ Arthritis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack or angina
- ☐ Congestive heart failure
- ☐ Emphysema (COPD)
- ☐ Diabetes
- ☐ Heartburn or reflux disease
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Cancer – if so, list what kind: _____ _____
- ☐ Chronic pain
- ☐ Thyroid disease
- ☐ Head injury or concussion
- ☐ Stroke of TIA's
- ☐ Alzheimer's disease
- ☐ Parkinson's disease
- ☐ Osteoporosis
- ☐ Sleep apnea
- ☐ Cataracts
- ☐ Frequent falls
- ☐ Other: _____

Please check any other health concerns you have had in the last month:

- ☐ Weight loss
- ☐ Change in appetite
- ☐ Problems sleeping
- ☐ Can't concentrate
- ☐ Poor memory
- ☐ Trouble finding words
- ☐ Sadness or anxiety
- ☐ Worrying or anxiety
- ☐ Irritability
- ☐ Shakiness or tremor
- ☐ Frequent urination
- ☐ Changes in vision
- ☐ Weakness
- ☐ Get tired or fatigued easily
- ☐ Dizziness
- ☐ Headaches
- ☐ Chest pain
- ☐ Short of breath
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Fever
- ☐ Rash

Have you had any surgeries? If so, please list: _____

_____

_____

_____

_____

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Please indicate if you use or have used any of the following substances:

Tobacco: ☐ Past ☐ Current amount: _____
Alcohol: ☐ Past ☐ Current amount: _____
Marijuana: ☐ Past ☐ Current amount: _____

Please answer the following questions about drinking alcohol:

One drink is any of the following: 1 can or bottle of beer, 1 cocktail, 1 glass of wine, 1 shot of hard liquor

How often did you have drinks containing alcohol in the last year?
☐ Never ☐ Monthly ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4 or more times per week
How many drinks did you have on a typical day when you were drinking in the last year?
☐ None or 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
How often did you have 6 or more drinks on one occasion in the last year?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
Have you ever sought treatment for alcohol or other substance abuse?
☐ No ☐ Yes

For each of the activities below, please check the appropriate box.

	I can do this myself	I need help doing this, but I have adequate help	I need help doing this, and do not have adequate help
Driving	☐	☐	☐
Paying my bills	☐	☐	☐
Housekeeping	☐	☐	☐
Making my meals	☐	☐	☐
Grocery shopping	☐	☐	☐
Using the phone	☐	☐	☐
Taking my medications	☐	☐	☐
Feeding myself	☐	☐	☐
Getting to the restroom in time	☐	☐	☐
Walking	☐	☐	☐
Getting dressed in the morning	☐	☐	☐
Bathing regularly	☐	☐	☐

Caffeine Intake

Caffeine (coffee, tea, soda, pills) intake each day: ☐ No ☐ Yes

How many cups, glasses, cans, or pills per day: _____

Any negative effects from caffeine (sleep impairment, anxiousness, heart palpitations): _____

_____

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Exercise

Exercise (biking, walking, yoga, jogging, etc.) _____

How many times per week? _____

Education/Job

What is your highest level of education? _____

Are you working/volunteering? ☐ No ☐ Yes

What is/was your primary occupation? _____

Please describe any prior mental health treatment you have received:

Do you currently have or have you in the past, worked with a psychiatrist, psychologist, or counselor? If so, who?

_____

_____

Have you used psychiatric medications such as sleeping pills, antidepressants, antianxiety pills, mood stabilizers, antipsychotic medications, and ADHD medications? If so, please list:

_____

_____

Hospitalizations: _____

_____

_____

Other: _____

_____

_____

What do you want to achieve with a psychiatric evaluation and, if needed, treatment?

_____

_____

_____

_____

_____

Signature of Patient/Representative: _____ Date: _____/_____/_____Time: _____
If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent/Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other: _____

Reviewed by: _____ Date: _____/_____/_____Time: _____