

S+AGE™

Specialized Ambulatory Geriatric Evaluation
at Sherman Oaks Hospital

Appointment:

Doctor:

Dear New S+AGE™ Patient and/or Caregiver:

We are so pleased you chose S+AGE™ at Sherman Oaks Hospital to assist you with your health care needs. Please take a few minutes to complete these health forms to the best of your ability. The information you provide is very important in our evaluation process. The more complete the information we have about your previous and current health, the more comprehensive and accurate an evaluation we can offer you.

We need the Authorization for Use or Disclosure of Medical Information and the Notice of Cancellation Fees forms returned to us **immediately** by mail or fax, if possible.

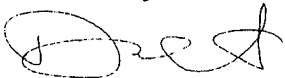
Please bring the following to your **first appointment**:

- **Completed Medical History Questionnaire**
- **Insurance Cards**
- **Durable Powers of Attorney for Health Care & Finances**
- **ALL of your medications (including over-the-counter medications)**

PLEASE ARRIVE 15 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TO ALLOW FOR REGISTRATION PAPERWORK.

Thank you for your cooperation. Should you have any questions, please do not hesitate to call our Office Manager, Marcella Valles at (818) 341-7243.

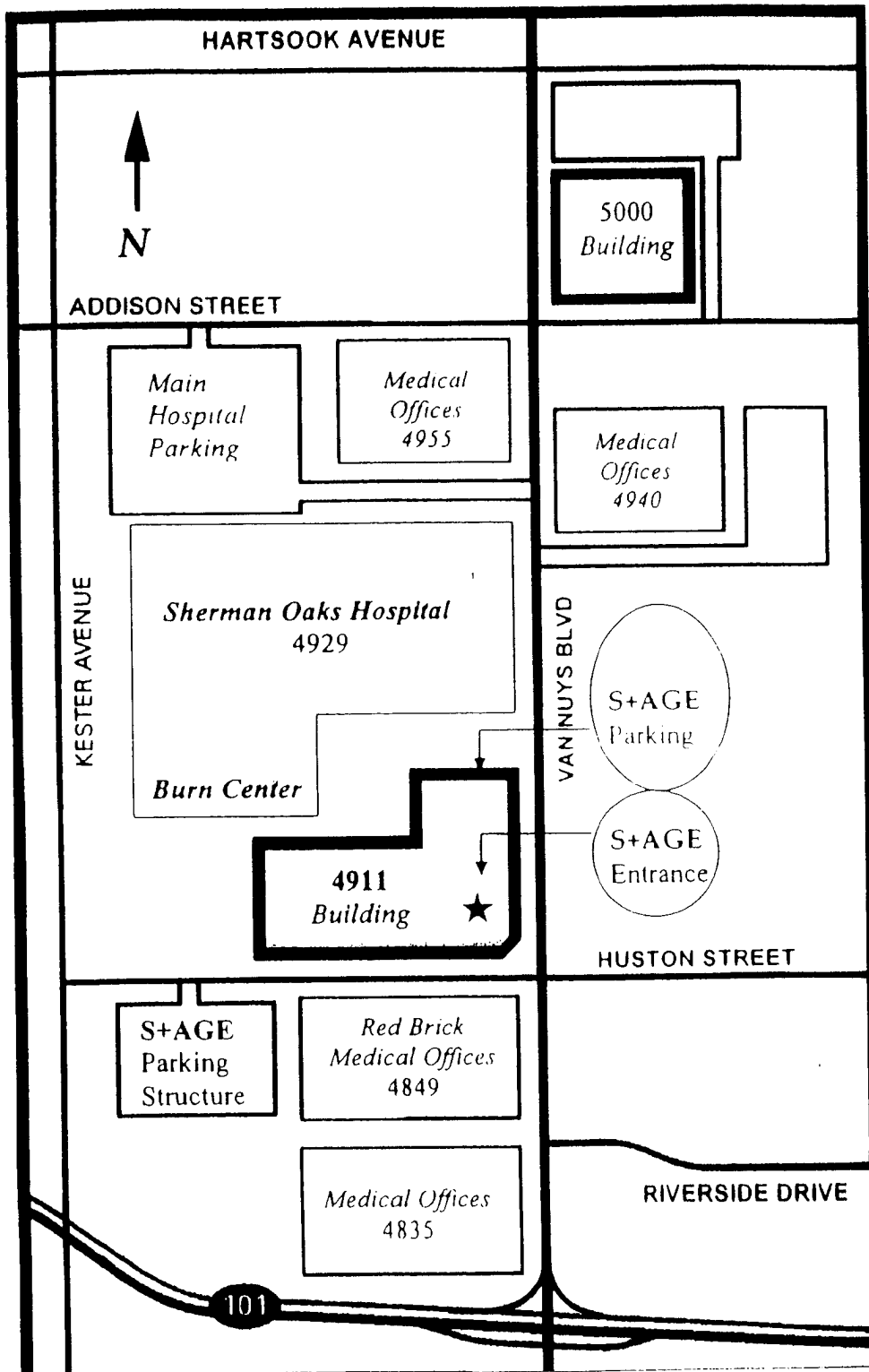
Sincerely,



Dan Osterweil, M.D.
Medical Director

S+AGE

Specialized Ambulatory Geriatric Evaluation
4911 Van Nuys Blvd., Suite 100
Sherman Oaks, CA 91403
(818) 341-7243



We are located off the 101 Freeway, south of the 405 Freeway. Take the Van Nuys Blvd exit off the 101 and head North.

If traveling on Van Nuys Blvd from the north, continue past the Hospital (on your right) to our location.

We have 4 S+AGE parking spots located in front of the Burn Center, between the hospital and our building. (Under the archway).

We also have parking in the structure on Huston St. We will validate parking for this structure.

NOTICE of CANCELLATION FEES

Due to the comprehensive nature of our assessments, one to two hours will be devoted to your needs at the following appointments:

- Initial Geriatric Assessment (2 hours)
- Neuropsychological Testing (2 hours)
- Care Planning Visit (1 hour)
- Psychotherapy (1 hour)

Last minute cancellations of these appointments make it difficult for us to continue to provide this level of service.

My signature below indicates that I understand that cancellation of my appointments as listed above, without notice of 2 business days, is subject to a \$100 cancellation fee.

Signature

Date

Received By: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

EXPLANATION: Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information may invalidate this Authorization.

Name of Patient _____
Date of Birth: _____ SSN: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

AUTHORIZATION:

I hereby authorize: S+AGE-- Dr. Stern, Dr. Osterweil, Dr. Swain, Dr. Watson, & Staff
to exchange with:
Name (Persons / Organizations): _____
Address: _____
Phone: _____

The following information:

- a. All health information pertaining to my medical history, mental or physical conditions and treatment received - OR
- Only the following records or types of health information (including any dates):
Recent H&P, Labs, X-rays, MRI - Brain and Speciality Consults

b. I specifically authorize release of the following information (**INITIAL AS APPROPRIATE**):

- **-----> _____ Mental Health treatment information
- _____ Alcohol and/or drug
- _____ HIV test result/disease

PURPOSE:

Purpose of requested use, exchange or disclosure: Patient request; OR other:
Provision of Care/Continuity of Care

EXPIRATION:

This authorization expires on: _____

MY RIGHTS:

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
I may revoke this authorization at any time, but I must do so in writing and submit it to: S+AGE at Sherman Oaks Hospital, 4911 Van Nuys Blvd., Suite 100, Sherman Oaks, CA 91403
My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.
I have a right to receive a copy of this authorization.
Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA)

SIGNATURE:

**----->Signature: _____
(patient/representative/spouse/financially responsible party)

Date: _____ Time: _____ am/pm

If signed by other than patient, indicate relationship: _____

WITNESS: _____

MEDICAL HISTORY QUESTIONNAIRE: INITIAL VISIT

Today's date: _____

1. Name: _____

2. Address: _____
street address Apartment number
_____ city state zip

3. Phone: (_____) _____

4. What is your date of birth? _____ / _____ / _____ Age _____
month day year

5. Sex: 1) _____ Male
2) _____ Female

6. Who filled out this form? _____
Relationship, if other than patient _____

7. Who has been your primary doctor?
Name: _____
Address: _____
Phone number: _____

8. Do you plan to continue to be followed by this doctor?
1) _____ NO
2) _____ YES
3) _____ Not Sure

9. What is your reason for this evaluation? _____

PAST MEDICAL HISTORY

10. List hospitalizations other than surgeries. Use back of page, if needed

DATE	REASON

11. List **surgeries** (operations).

DATE	SURGERY (OPERATIONS)

PREVENTIVE HEALTH

12. Have you ever had an examination of your bowel with a scope (sigmoidoscopy or colonoscopy)?
 1) NO
 2) YES. → If YES, When did you have your most recent sigmoidoscopy or colonoscopy? _____ (year)
13. In the **past 12 months**, have you had a test for blood in your stool (three cards at home)?
 1) NO
 2) YES
14. Have you ever had the **Pneumovax vaccine** (a shot to prevent pneumonia)?
 1) NO
 2) YES → If YES, In what year did you have your last vaccine? _____ (year)
15. Have you ever had a **tetanus shot**?
 1) NO
 2) YES. → If YES, In what year did you have your last tetanus booster? _____ (year)
16. Have you had a **flu shot this season** (October – February)?
 1) NO
 2) YES
 3) Not applicable (March – September)
17. Have you had a **TB skin test**? No Yes Negative Positive _____ Year
18. When was your last **dental visit**? _____ Month/Year
19. When was your last **eye exam**? _____ Month/Year
20. Have you ever had a **Bone Density Test**? No Yes _____ Year

QUESTIONS FOR MEN ONLY

21. Have you ever had a prostate exam (rectal exam)?
 1) NO
 2) YES. → If YES, When did you have your most recent prostate exam? _____ (year)
22. Have you ever had a blood test to look for cancer of the prostate (PSA)?
 1) NO
 2) YES. → If YES, When did you have your most recent blood test to look prostate cancer? _____ (year)

QUESTIONS FOR WOMEN ONLY

23. Do you perform breast self-exam (BSE) once a month?
1) NO
2) YES
24. Have you ever had a mammogram?
1) NO
2) YES. → If YES, Have you had a mammogram within the last 2 years?
a) no
b) yes, month _____ year _____
25. Have you had a hysterectomy (surgical removal of the uterus)?
1) YES (go to question 26)
2) NO. → If NO, Have you ever had a Pap smear/pelvic examination?
a) no (go to question 26)
b) yes. If yes, When was your last Pap smear? Month _____ year _____

Do you have any other health problems that you would like your doctor to know about.

FAMILY HISTORY

26. Have any **members of your family** had any of the following conditions? (check all that apply)
- 1) Dementia or Alzheimer's disease
 - 2) Cancer, of what? _____
 - 3) Heart disease
 - 4) Stroke
 - 5) Diabetes
 - 6) Depression
 - 7) None of these

SOCIAL HISTORY

29. With whom do you live? (check one)
- 1) _____ Alone
 - 2) _____ With spouse or partner
 - 3) _____ With child or other family
 - 4) _____ Others, not family specify _____
30. Which of the following best describes your residence? (check one)
- 1) _____ Own house or condo
 - 2) _____ Rent house, condo or apartment
 - 3) _____ Live with other in their home, condo or apartment
 - 4) _____ Retirement hotel
 - 5) _____ Board and care/residential care facility
 - 6) _____ Other, specify _____
31. Are you currently (check one)
- 1) _____ Married
 - 2) _____ Divorced/Separated
 - 3) _____ Widowed
 - 4) _____ Single/Never married
32. Are you currently (check one)
- 1) _____ Retired
 - 2) _____ Working at least part-time
 - 3) _____ Looking for work
33. What has been your principal occupation? _____
34. How much school did you complete? (check one)
- 1) _____ Less then 6th grade
 - 2) _____ Less than high school graduate
 - 3) _____ High school graduate
 - 4) _____ Some college
 - 5) _____ College graduate
 - 6) _____ More than college graduate
35. Do you have a **medical Durable Power of Attorney**? Yes No Don't know
Name: _____ Relationship: _____ Phone #: _____
36. Do you have a **Power of Attorney for Asset (financial) Management**?
 Yes No Don't know
37. Do you have a living will or Trust ? (Check one or both).
Do you have a copy? Yes No Who does? _____

HEALTH

38. Do you drink **alcohol**, including beer and wine? (check one)

- 1) _____ Daily
- 2) _____ Greater than 3 times a week
- 3) _____ 1 to 3 times a week
- 4) _____ Less than 1 time a week
- 5) _____ Never

39. Have you ever smoked **cigarettes**?

- 1) ___ NO
- 2) ___ YES. → If YES, **Are you now smoking?**
 - a) _____ **no**, if no,
 - 1. How many years ago did you quit? _____
 - 2. For how many years did you smoke? _____
 - 3. How much did you smoke? _____ packs per day
 - b) _____ **yes**, if yes,
 - 1. How many years have you smoked? _____
 - 2. How much do you smoke? _____ pack per day

40. Do you always wear a seatbelt when you ride in a car?

- 1) ___ NO
- 2) ___ YES

DIET

41. Are you on a special diet? _____

42. Do you have difficulty eating? No Yes Explain _____

43. Do you currently participate in any regular activity or program designed to improve or maintain your physical fitness? (either on your own or in a formal class)

- 1) ___ NO
- 2) ___ YES → If YES, **Check what you do currently.**
 - a) _____ Walking
 - b) _____ Swimming
 - c) _____ Aerobics or exercise classes
 - d) _____ Dancing
 - e) _____ Jogging
 - f) _____ Bicycling or stationary bike
 - g) _____ Tennis
 - h) _____ Golf
 - i) _____ Bowling or boccie
 - j) _____ None of the above
 - k) _____ Other: specify _____

44. What hobbies or leisure activities do you have? _____

REVIEW OF SYSTEMS

45. Would you rate your overall health as:

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

46. Which medical conditions do you have or have you had in the past? (Check all that apply)

I. EYE & EAR PROBLEMS

- a) ___ Cataracts
- b) ___ Glaucoma
- c) ___ Macular degeneration of the eye
- d) ___ Hearing loss/Hearing aid
- e) ___ Other, specify _____

II. HEART PROBLEMS

- a) ___ Angina
- b) ___ Heart attack: _____ year
- c) ___ Heart failure
- d) ___ High blood pressure
- e) ___ Irregular heart beats
- f) ___ Other, specify _____

III. LUNG PROBLEMS

- a) ___ Asthma
- b) ___ Bronchitis
- c) ___ Emphysema
- d) ___ Other, specify _____

IV. BONE & JOINT PROBLEMS

- a) ___ Arthritis
- b) ___ Osteoporosis
- c) ___ Fractured hip, wrist or spine (circle which one)
- d) ___ Gout
- e) ___ Other, specify _____

V. GLAND PROBLEMS

- a) ___ Diabetes
- b) ___ Thyroid overactive (high)
- c) ___ Thyroid underactive (low)
- d) ___ Other, specify _____

VI. KIDNEY & URINARY TRACT PROBLEMS

- a) ___ Kidney disease
- b) ___ Prostate disease
- c) ___ Frequent bladder or kidney infections
- d) ___ Other, specify _____

VII. GASTROINTESTINAL PROBLEMS

- a) ___ Ulcers
- b) ___ Heartburn/Hiata Hernia
- c) ___ Diverticulosis
- d) ___ Liver disease/Cirrhosis
- e) ___ Hepatitis
- f) ___ Polyps
- g) ___ Gallbladder disease
- h) ___ Other, specify _____

VIII. NERVOUS SYSTEM PROBLEMS

- a) ___ Stroke
- b) ___ Dementia/Alzheimer's
- c) ___ Parkinson's disease
- d) ___ Epilepsy/Seizures
- e) ___ Other, specify _____

IX. OTHER HEALTH PROBLEMS

- a) ___ Anemia
- b) ___ Hernia
- c) ___ Thrombosis (blood clots)
- d) ___ Cancer, of what _____?
- e) ___ Depression
- f) ___ Sexual function problems, specify _____
- g) ___ Sleep
- h) ___ Other, specify _____

47. During the past 12 months, have you ever lost your urine or gotten wet?

- 1) ___ NO
- 2) ___ YES. → If YES, Have you lost urine on at least six separate days?
 - a) ___ no
 - b) ___ yes

48. _____ Check if you do not now or did not have any of these problems.

49. To be certain that we've covered everything, during the **last three months**, have you had any of the following symptoms or problems? (check all that apply)

I. **EYE or EAR PROBLEMS**

- a) ___ Visual or eye problems
- b) ___ Hearing difficulty or ear trouble

II. **HEART PROBLEMS**

- a) ___ Chest pain or tightness
- b) ___ Rapid or irregular heart beat
- c) ___ Edema

III. **LUNG PROBLEMS**

- a) ___ Persistent cough
- b) ___ Difficulty breathing or shortness of breath

IV. **DIGESTION PROBLEMS**

- a) ___ Dental problems
- b) ___ Difficulty swallowing
- c) ___ Frequent indigestion or stomach ache
- d) ___ Frequent nausea or vomiting
- e) ___ Change in bowel habits
- f) ___ Weight loss. How many pounds _____?
- g) ___ Black bowel movement or bleeding from rectum
- h) ___ Frequent diarrhea
- i) ___ Persistent constipation

V. **BONE & JOINT PROBLEMS**

- a) ___ Leg pain on walking
- b) ___ Back or neck pain
- c) ___ Joint pain or stiffness
- d) ___ Foot problems

VI. **BRAIN & NERVOUS SYSTEM PROBLEMS**

- a) ___ Frequent headaches
- b) ___ Frequent dizzy spells
- c) ___ Passing out or fainting
- d) ___ Paralysis, leg or arm weakness
- e) ___ Numbness or loss of feeling
- f) ___ Serious problem with memory or difficulty thinking
- g) ___ Tremor or shaking

VII. **GYNECOLOGY PROBLEMS**

- a) ___ Vaginal bleeding after you stopped having your periods
- b) ___ Breast lumps or discomfort
- c) ___ Vaginal discharge

VIII. **KIDNEY & URINARY TRACT PROBLEMS**

- a) ___ Urination at night
- b) ___ Frequent urination
- c) ___ Painful urination
- d) ___ Difficulty starting or stopping urination

IX. **OTHER HEALTH PROBLEMS**

- a) ___ Difficulty with sleeping
- b) ___ Falling or stumbling
- c) ___ Swelling feet or ankles
- d) ___ Fever or sweats
- e) ___ Other: _____

..... **PAIN ASSESSMENT**

50. a. During the **past three months** have you experienced pain? Yes No
 b. Where is the pain? _____
 c. Circle your pain rating as 1 minimal pain, to 10 most severe pain.
 No pain 1 2 3 4 5 6 7 8 9 10 Most severe pain
 c. Pain relief measures: Medication Other _____
 d. Effectiveness: Very Mostly Sometimes Rarely Not at all

_____ Check here if you **have not** had any of these problems during the last 3 months.

DEPRESSION

51. How much of the time, **during the past month** have you felt downhearted and blue? (circle)
- All the time Most of the time Some of the time Little of the time None

FUNCTIONAL STATUS

52. We want to know if you need help with any of the following, and who helps you. Fill out for each task.

TASK	DON'T NEED HELP	NEED HELP	IF YOU NEED HELP, WHO HELPS? (Name and Relationship)
Feeding yourself 1B			
Getting from bed to chair 1B			
Getting to the toilet 1B			
Getting dressed 1B			
Bathing 1B			
Using the telephone 1i			
Taking your medicines 1i			
Preparing meals 1i			
Managing money/financial affairs/checkbook 1i			
Doing laundry 1i			
Doing house work 1i			
Shopping for groceries 1i			
Driving 1i			
Doing "handyman" work 1a			
Climbing a flight of stairs 1a			
Getting to places beyond walking distance 1a			

SCORES	BADL	IADL	AADL
	6	6	6

53. Do you **employ** someone to provide care or help you in your home?

1) _____ NO

2) _____ YES → If YES, How many hours a day and how many days a week is your paid helper available for you? _____ hours a day and _____ days a week

54. Is this sufficient to meet your needs?

1) _____ NO

2) _____ YES

55. Do you get help from a family member or friend in your home?

1) _____ NO

2) _____ YES → If YES, How many hours a day and how many days a week is your family member or friend available for you? _____ hours a day and _____ days a week

56. Is this sufficient to meet your needs?

1) _____ NO

2) _____ YES

57. Do you provide care for a family member?

1) _____ NO

2) _____ YES

MD/NP Signature: _____ Date: _____ Time: _____