Internal & Respiratory Medicine Specialty Clinic

Older Adult Health Questionnaire

Please complete this form only if requested by the clinic. A family member or caregiver may help if needed.

Think about your health and day-to-day function over roughly the past month. Check the option that best fits. If a question does not apply, leave it blank or choose “Not sure / N/A” where available.

MEMORY, MOOD & COMMUNICATION

Question	Yes	Sometimes	No	Not sure
Have you noticed changes in your memory, concentration, or ability to understand information?				
Have you felt sad, low, or less interested in activities you normally enjoy?				
Have you felt unusually worried, nervous, or on edge?				
Have you had much less energy than usual?				
Have you had unusual experiences such as seeing or hearing things that others do not?				
Have you felt unusually suspicious, unsafe, or worried that others may harm you?				
Do you have difficulty speaking or finding words?				
Do you have difficulty hearing conversations?				
Do you have difficulty seeing well enough for everyday activities?				

If you have concerns about memory, mood, or communication, please describe them:

_____

_____

_____

MOBILITY, BALANCE & FALLS

Question	Yes	Sometimes	No	Not sure
Do you feel weak in your arms or hands?				
Do you feel weak in your legs?				
Do you feel unsteady when standing or walking?				
Have you fallen or nearly fallen recently?				
Do you use a cane, walker, wheelchair, or another mobility aid?				

If you use a mobility aid, what do you use? _____

If you have fallen, briefly describe what happened _____

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Older Adult Health Questionnaire - Daily Activities

For each activity, mark the response that best reflects what you can usually do.

Activity	Independent	Need some help	Unable	N/A
Walk outdoors or in an unfamiliar place				
Walk around inside your home				
Stand up from a chair or move between positions				
Get into and out of bed				
Eat and drink independently				
Bathe or shower				
Dress yourself				
Use the toilet				
Prepare a simple meal				
Do routine household cleaning				
Shop for groceries or essentials				
Manage and take your medications				
Drive or arrange transportation				
Manage banking and finances				
Pay bills and keep track of appointments				

SLEEP, APPETITE, BOWEL & BLADDER

Question	Yes	Sometimes	No	Not sure
Are you generally sleeping well at night?				
Do you feel very sleepy during the day?				
Is your sleep often interrupted?				
Do you have trouble falling asleep?				
Is your appetite about the same as usual?				
Do you have frequent constipation or difficulty with bowel movements?				
Do you have difficulty controlling your bladder?				
Do you have difficulty controlling your bowels?				

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Older Adult Health Questionnaire - Home & Supports

LIVING SITUATION & SOCIAL SUPPORT

Relationship status: [ ] Married / partnered [ ] Single [ ] Divorced / separated [ ] Widowed [ ] Prefer not to say

I live: [ ] Alone [ ] With spouse / partner [ ] With family [ ] With others

Residence: [ ] House [ ] Apartment / condo [ ] Retirement / assisted living [ ] Long-term care [ ] Other: _____

If in a house, number of levels _____

Approximate number of steps to enter _____

Support available: [ ] Family / friends [ ] Paid caregiver [ ] Home care / nursing [ ] Other: _____

If you have a caregiver, relationship to you _____

Any caregiver concerns or stress we should know about _____

Social connection: Do you regularly speak with or spend time with family, friends, neighbours, or community groups? [ ] Yes [ ] Sometimes [ ] No

CARE PLANNING

Do you have a substitute decision-maker, power of attorney for personal care, or advance care plan? [ ] Yes [ ] No [ ] Not sure

Have you discussed your wishes for future medical care with your family or healthcare team? [ ] Yes [ ] No [ ] Not sure

If there is anything important you would like the clinic to know about your goals, values, or care preferences, please write it below:

_____
_____
_____
_____
_____

Important: This questionnaire is for clinical review and does not replace a medical assessment. If you have an urgent health concern, contact an appropriate healthcare service or emergency service.