MSD MANUAL
Professional Version

History-Taking in the Older Adult

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Attention to the medical history is particularly important in older adults because the history is often more complicated than in younger patients, and information may need to be gathered from a variety of sources (see also Overview of the Evaluation of the Older Adult). Often, more time is needed to interview and evaluate older patients, partly because they may have characteristics that interfere with the evaluation. The following should be considered:

- **Sensory deficits:** Dentures, eyeglasses, or hearing aids, if normally worn, should be worn to facilitate communication during the interview. Adequate lighting and elimination of visual or auditory distraction also help.
- **Underreporting of symptoms:** Older patients may not report symptoms that they may incorrectly consider part of normal aging (eg, dyspnea, hearing or vision deficits, memory problems, incontinence, gait disturbance, constipation, dizziness, falls). However, no symptom should be attributed to normal aging unless a thorough evaluation is done and other possible causes have been eliminated.
- **Unusual manifestations of a disorder:** In older adults, typical manifestations of a disorder may be absent. Instead, older patients may present with nonspecific symptoms (eg, fatigue, confusion, weight loss).
- **Functional decline as the only manifestation:** Disorders may manifest solely as functional decline. In such cases, standard questions may not apply. For example, when asked about joint symptoms, patients with severe arthritis may not report pain, swelling, or stiffness, but if asked about changes in activities, they may, for example, report that they no longer take walks or volunteer at the hospital. Questions about duration of functional decline (eg, “How long have you been unable to do your own shopping?”) can elicit useful information. Identifying people when they have just started to have difficulty doing basic activities of daily living (ADLs) or instrumental ADLs may provide more opportunities for interventions to restore function or to prevent further decline and thus maintain independence.
- **Difficulty recalling:** Patients may not accurately remember past illnesses, hospitalizations, operations, and medication use; clinicians may have to obtain these data elsewhere (eg, from family members, a home health aide, or medical records).

- **Fear:** Older adults may be reluctant to report symptoms because they fear hospitalization, which they may associate with dying.
- **Age-related disorders and problems:** Depression (common among older adults who are vulnerable and sick), the cumulative losses of old age, and discomfort due to a disorder may make older adults less apt to provide health-related information to clinicians. Patients with impaired cognition may have difficulty describing problems, impeding the clinician's evaluation.

Interview of the Older Patient

A clinician's knowledge of an older patient's everyday concerns, social circumstances, mental function, emotional state, and sense of well-being helps orient and guide the interview. Asking patients to describe a typical day elicits information about their quality of life and mental and physical function. This approach is especially useful during the first meeting. Patients should be given time to speak about things of personal importance. Clinicians should also ask whether patients have specific concerns, such as fear of falling. The resulting rapport can help the clinician communicate better with patients and their family members.

A mental status examination should be done early in the interview to determine the patient's reliability; this examination should be conducted tactfully so that the patient does not become embarrassed, offended, or defensive. Routine screening for physical and psychologic disorders (see table Selected Screening Recommendations for Older Patients) should be done annually beginning at age 65. This screening is done as part of the initial Welcome to Medicare Exam and yearly as part of the Medicare Annual Wellness Exam (AWE).

Often, verbal and nonverbal clues (eg, the way the story is told, tempo of speech, tone of voice, eye contact) can provide information, as for the following:

- **Depression:** Older patients may omit or deny symptoms of anxiety or depression but betray them by a lowered voice, subdued enthusiasm, or even tears.
- **Physical and mental health:** What patients say about sleep and appetite may be revealing.
- **Weight gain or loss:** Clinicians should note any change in the fit of clothing or dentures.

Unless mental status is impaired, a patient should be interviewed alone to encourage the discussion of personal matters. Clinicians may also need to speak with a relative or caregiver, who often gives a different perspective on function, mental status, and emotional state. These interviews may be done with the patient absent or present.

The clinician should ask the patient's permission before inviting a relative or caregiver to be present and should explain that such interviews are routine. If the caregiver is interviewed alone, the patient should be kept usefully occupied (eg, filling out a standardized assessment questionnaire, being interviewed by another member of the interdisciplinary team).

If indicated, clinicians should consider the possibility of drug abuse by the patient and patient abuse by the caregiver.

Medical History in the Older Patient

When asking patients about their past medical history, a clinician should ask about disorders that used to be more common (eg, rheumatic fever, poliomyelitis) and about outdated treatments (eg, pneumothorax therapy for tuberculosis, mercury for syphilis). A history of immunizations (eg, COVID-19, influenza, pneumococcus, tetanus), adverse reactions to immunizations, and skin test results for tuberculosis is needed. If patients recall having surgery but do not remember the procedure or its purpose, surgical records should be obtained if possible.

Clinicians should ask questions designed to systematically review each body area or system (review of systems) to check for other disorders and common problems that patients may have forgotten to mention (see table Clues to Disorders in Older Patients).

TABLE

Clues to Disorders in Older Patients

Organ or System	Symptom	Possible Causes
Skin	Itching	Allergic reaction, cancer, dry skin, hyperthyroidism, jaundice, lice, scabies, uremia
Head	Headaches	Anxiety, cervical osteoarthritis, depression, giant cell arteritis, subdural hematoma, tumors
Eyes	Glare from lights at night	Cataracts, glaucoma
	Loss of central vision	Macular degeneration
	Loss of near vision (presbyopia)	Decreased accommodation of the lens
	Loss of peripheral vision	Glaucoma, retinal detachment, stroke
	Pain	Giant cell arteritis, glaucoma
Ears	Hearing loss	Vestibular schwannoma (acoustic neuroma), cerumen, foreign body in the external canal, ototoxicity due to use of medications (eg, aminoglycosides, aspirin, furosemide), Paget disease, presbycusis, trauma due to noise, tumor of the cerebellopontine angle, viral infection
	Loss of high-frequency range,often difficulty understanding speech	Presbycusis (usually caused by age-related changes in the cochlea)

Mouth	Burning mouth	Pernicious anemia, stomatitis
	Denture pain	Dentures that fit poorly, oral cancer
	Dry mouth (xerostomia)	Systemic rheumatic diseases (eg, rheumatoid arthritis, Sjögren syndrome, systemic lupus erythematosus), dehydration, medications (eg, antidepressants including tricyclic antidepressants, antihistamines, anti hypertensives, diuretics), psychoactive medications or illicit drugs, salivary gland damage due to infection or to radiation therapy for head and neck tumors
	Limited tongue motion	Oral cancer, stroke
	Loss of taste	Adrenal insufficiency, medications (eg, antihistamines, antidepressants), infection of the mouth or nose, nasopharyngeal tumor, radiation therapy, smoking, xerostomia
Throat	Dysphagia	Anxiety, cancer, esophageal stricture, foreign body, Schatzki ring, stroke, Zenker diverticulum
	Voice changes	Hypothyroidism, recurrent laryngeal nerve dysfunction, vocal cord tumor
Neck	Pain	Cervical arthritis, carotid or vertebral artery dissection, polymyalgia rheumatica
Chest	Dyspnea during exertion	Cancer, COPD, functional decline, heart failure, infection
	Paroxysmal nocturnal dyspnea	Gastroesophageal reflux, heart failure
	Pain	Angina pectoris, anxiety, aortic dissection, costochondritis, esophageal motility disorders, gastroesophageal reflux, herpes zoster, myocardial infarction

		herpes zoster, myocardial infarction, myocarditis, pericarditis, pleural effusion, pleuritis, pneumonia, pneumothorax
Gastrointestinal	Constipation with no other symptoms	Colorectal cancer, dehydration, medications or illicit drugs (eg, aluminum-containing antacids, medications with anticholinergic effects, iron supplements, opioids, tricyclic antidepressants), hypercalcemia (eg, due to hyperparathyroidism), hypokalemia, hypothyroidism, inadequate exercise, laxative abuse, low-fiber diet
	Constipation with pain, vomiting, and intermittent diarrhea	Fecal impaction, bowel obstruction
	Fecal incontinence	Cerebral dysfunction, fecal impaction, malabsorption, ischemic colitis, intestinal tumors, rectal cancer, spinal cord lesions
	Lower abdominal pain (crampy, sudden onset)	Diverticulitis, gastroenteritis, ischemic colitis, obstruction
	Postprandial abdominal pain (2–3 hours after eating, lasting 1–3 hours)	Chronic intestinal ischemia
	Rectal bleeding	Colon angiodysplasia, colorectal cancer, diverticulosis, hemorrhoids, ischemic colitis
	Frequency, dribbling, hesitancy, weak stream	Benign prostatic hyperplasia, constipation, medications or illicit drugs (eg, antihistamines, opioids), prostate cancer, urinary retention, urinary tract infection
	Dysuria with or without fever	Prostatitis, urinary tract infection

Genitourinary	Polyuria	Diabetes insipidus (decrease in antidiuretic hormone action), diabetes mellitus, diuretics
	Incontinence	Cystitis, functional decline, normal-pressure hydrocephalus, spinal cord dysfunction, stroke, urinary retention or overflow, urinary tract infection
Musculoskeletal	Back pain	Abdominal aortic aneurysm, compression fractures, infection, metastatic cancer, multiple myeloma, osteoarthritis, Paget disease, pyelonephritis, spinal stenosis
	Proximal muscle pain	Myopathies, polymyalgia rheumatica, use of statins
Extremities	Leg pain	Intermittent claudication, night cramps, osteoarthritis, radiculopathy (eg, disk herniation, lumbar stenosis), restless legs syndrome
	Swollen ankles	If swelling is bilateral, heart failure, hypoalbuminemia, or renal insufficiency; if unilateral or bilateral, venous insufficiency
	Change in mental status with fever	Delirium, encephalitis, meningitis, sepsis
	Change in mental status without fever	Acute illness, cognitive dysfunction, fecal impaction, delirium, depression, medications or illicit drugs, psychiatric disorders, urinary retention
	Clumsiness in tasks requiring fine motor coordination (eg, buttoning shirt)	Arthritis, parkinsonism, spondylotic cervical myelopathy, intention tremor
	Excessive sweating during meals	Autonomic neuropathy

Neurologic	Fall without loss of consciousness	Bradycardia, drop attack, neuropathy, orthostatic hypotension, postural instability, tachycardia, transient ischemic attack, vision impairment
	Hesitant gait with intention tremor	Parkinson disease
	Numbness with tingling in fingers	Carpal tunnel syndrome, peripheral neuropathy, spondylotic cervical myelopathy
	Sleep disturbances	Anxiety, circadian rhythm disturbances, depression, medications or illicit drugs, pain, parkinsonism, periodic limb movement disorder, sleep apnea, urinary frequency
	Syncope	Aortic stenosis, cardiac arrhythmia, hypoglycemia, orthostatic hypotension (especially medication-related), seizure
	Transient interference with speech, muscle strength, sensation, or vision	Transient ischemic attack
	Tremor	Alcohol use disorder, central nervous system disorder (eg, cerebellar disorders, poststroke), essential tremor, hyperthyroidism, parkinsonism

Medication History in the Older Patient

The medication history should be recorded, and a copy should be given to patients or their caregiver. It should contain

- Medications used
- Dose
- Dosing schedule
- Prescriber

- Reason for prescribing the medications
- Precise nature of any medication allergies

All medications and other substances used should be recorded, including

- Topical medications (which may be absorbed systemically)
- Over-the-counter medications (which can have serious consequences if overused and may interact with prescription medications)
- Dietary supplements
- Medicinal herb preparations (because many can interact adversely with prescription and over-the-counter medications)
- Alcohol
- Caffeine
- Other illicit drugs (eg, marijuana)

Patients or family members should be asked to bring in all of the above drugs and supplements at the initial visit and periodically thereafter. Clinicians can make sure patients have the prescribed medications, but possession of these medications does not guarantee adherence. Counting the number of tablets in each vial during the first and subsequent visits may be necessary. If someone other than a patient administers the medications, that person is interviewed.

Patients should be asked to show their ability to read labels (often printed in small type), open containers (especially the child-resistant type), give themselves treatments using a device such as an inhaler, and recognize medications. Patients should be advised not to put their medications into one container.

Alcohol, Smoking, and Inappropriate Drug Use History

Patients should be checked for signs of alcohol use disorders, which are underdiagnosed in older adults. Such signs include confusion, anger, hostility, alcohol odor on the breath, impaired balance and gait, tremors, peripheral neuropathy, and nutritional deficiencies. Screening questionnaires and questions about quantity and frequency of alcohol consumption can help.

The Short Michigan Alcohol Screening Test-Geriatric Version (or SMAST-G) is a 10-question test designed for people ≥ 65 (see Screening for Alcohol Use and Misuse in Older Adults). It is usually preferred to other screening questionnaires (eg, CAGE, AUDIT) that were not designed for older adults. Two or more "yes" responses suggest the possibility of an alcohol use disorder.

1. When talking with others, do you ever underestimate how much you drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to relax or calm your nerves?

6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does having a drink help?

Patients who smoke tobacco should be counseled to stop and, if they continue to smoke, not to smoke in bed because older adults are more likely to fall asleep while doing so. Patients who use e-cigarettes and vape products should be warned about the risks of nicotine addiction and pulmonary injury.

Patients who take drugs and other substances (eg, alcohol, marijuana, tobacco, caffeine, hallucinogens, sometimes opioids) should be counseled about risk of addiction and possible interactions with prescription and other medications.

Nutrition History in the Older Patient

Type, quantity, and frequency of food eaten are determined. Patients who eat ≤ 2 meals a day are at risk of undernutrition. Clinicians should ask about the following:

- Any special diets (eg, low-salt, low-carbohydrate) or self-prescribed fad diets
- Intake of dietary fiber and prescribed or over-the-counter vitamins
- Weight loss and change of fit in clothing
- Amount of money patients have to spend on food
- Accessibility of food stores and suitable kitchen facilities
- Variety and freshness of foods

The ability to eat (eg, to chew and swallow) is evaluated. It may be impaired by xerostomia and/or dental problems, which are common among older adults. Decreased taste or smell may reduce the pleasure of eating, so patients may eat less. Patients with decreased vision, arthritis, immobility, or tremors may have difficulty preparing meals and may injure or burn themselves when cooking. Patients who are worried about urinary incontinence may inappropriately reduce their fluid intake, increasing their risk of dehydration.

Mental Health History in the Older Patient

Psychiatric disorders and behavioral health issues may not be detected easily in older patients. Symptoms that may indicate a psychiatric disorder or a behavioral health issue in younger patients (eg, insomnia, changes in sleep patterns, constipation, cognitive dysfunction, anorexia, weight loss, fatigue, preoccupation with bodily functions, increased alcohol consumption) may have another cause in older adults. Sadness, hopelessness, and crying episodes may indicate depression. Irritability may be the primary affective symptom of depression, or patients may present with cognitive dysfunction. Generalized anxiety is the most common psychiatric disorder encountered in older patients and is often accompanied by depression.

Patients should be asked about delusions and hallucinations, past mental health care (including psychotherapy, institutionalization, and electroconvulsive therapy), use of psychoactive medications or illicit drugs, and recent changes in circumstances. Many circumstances (eg, recent loss of a loved one, hearing loss, a change in residence or living situation, loss of independence) may contribute to depression.

Patients' spiritual and religious preferences, including their personal interpretation of aging, declining health, and death, should be clarified because these preferences and viewpoints affect their goals of care and quality of life.

Functional Status of the Older Patient

Whether patients can function independently, need some help with basic activities of daily living (ADLs) or instrumental ADLs, or need total assistance is determined as part of comprehensive geriatric assessment. Patients should be asked open-ended questions about their ability to do activities, or they may be asked to fill out a standardized assessment instrument with questions about specific ADLs and instrumental ADLs (eg, see tables Modified Katz ADL Scale and Lawton IADL Scale).

TABLE

Modified Katz Activities of Daily Living (ADL) Scale

Activity	Item	Score
Eating	Gets food from plate into mouth without help Food may be prepared by another person Eats without assistance	1
	Needs partial or complete assistance in eating or is fed intravenously	0
Dressing	Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	1
	Needs help with dressing or needs to be completely dressed	0
Bathing (sponge bath, tub bath, shower)	Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area, or disabled extremity	1
	Needs assistance in bathing more than one part of the body, getting in and out of the tub or shower, or needs total assistance	0
*Transferring	Moves in and out of bed or chair unassisted (mechanical transfer aids are acceptable)	1
	Needs help in moving from bed to chair or requires a complete transfer	0
Toileting	Goes to toilet, gets on and off, arranges clothes, and cleans genital area without help	1
	Needs help transferring to the toilet, cleaning self or uses bedpan or commode	0
Continence	Controls bladder and bowel completely (without occasional accidents)	1
	Is partially or totally incontinent of bowel or bladder	0

* Transferring is the only measure of mobility in the Katz ADL scale.

A score of 6 indicates the patient is independent, 4 indicates the patient has moderate impairment, and 0 indicates the patient is very dependent.

Katz S, Downs TD, Cash HR, et al: Progress in the development of the index of ADL. Gerontologist 10 (1):20–30, 1970 as modified by Try this: Best practices in nursing care to older adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

TABLE

Lawton Instrumental Activities of Daily Living Scale

Activity	Description	Score*
Using the telephone	Uses a telephone, including looking up and dialing numbers	1
	Dials a few familiar numbers	1
	Answers the telephone but does not dial	1
	Does not use the telephone	0
Shopping	Does all the shopping without help	1
	Shops for small items without help	0
	Needs to be accompanied whenever shopping	0
	Cannot do any shopping	0
Preparing food	Plans, prepares, and serves adequate meals without help	1
	If given the ingredients, prepares adequate meals	0
	Heat and serves prepared meals or prepares meals but ones that are nutritionally inadequate	0
	Needs someone to prepare and serve meals	0
Doing household tasks	Does household tasks without help or occasionally with help for physically demanding tasks (eg, washing windows)	1
	Does light housework (eg, dish washing, dusting)	1
	Does light housework but does not keep the house adequately clean	1

	Needs help with all household tasks	1
	Does not do any household tasks	0
Doing laundry	Does laundry without help	1
	Washes small items (eg, stockings)	1
	Needs someone to do all laundry	0
Traveling other than by walking	Uses public transportation without help or drives a car	1
	Calls for taxis but does not use other public transportation	1
	Uses public transportation if accompanied by someone to help	1
	Travels only by taxi or car and only if helped by someone	0
	Does not travel	0
Taking prescription medications as directed	Takes the correct doses of prescribed medications at the correct time without help	1
	Takes prescribed medications if they are prepared in advance in separate dosage	0
	Cannot dispense the prescribed medications	0
Managing money	Manages finances (eg, making a budget, writing checks, paying rent, keeping track of income) without help	1
	Buys small items needed on a daily basis but requires help with banking and major purchases	1
	Cannot manage money	0

* People are asked to choose the description that most closely matches their highest functional level. Tasks are scored as either 1 (if they can do a task) or 0 (if they cannot).

A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 to 5 for men. The score identifies areas of need in regard to care and support.

Adapted from Lawton MP, Brody EM: Assessment of older people: Self-maintaining and instrumental activities of daily living. Gerontologist 9 (3):179–186, 1969.

Social History in the Older Patient

Clinicians should obtain information about patients' living arrangements, particularly where and with whom they live (eg, alone in an isolated house, in a busy apartment building), accessibility of their residence (eg, up stairs or a hill), and what modes of transportation are available to them (see also Social Issues in Older Adults). Ownership of a smart phone and ability to use it to access ride-sharing, food delivery, and other supportive services should also be assessed. Such factors affect their ability to obtain food, health care, and other important resources. A home visit, although difficult to arrange, can provide critical information. For example, clinicians can gain insight about nutrition from the refrigerator's contents and about multiple ADLs from the bathroom's condition.

The number of rooms, number and type of phones, presence of smoke and carbon monoxide detectors, and condition of plumbing and heating system are determined, as is the availability of elevators, stairs, and air conditioning. Home safety evaluations can identify home features that can lead to falls (eg, poor lighting, slippery bathtubs, unanchored rugs), and solutions can be suggested.

Having patients describe a typical day, including activities such as reading, television viewing, work, exercise, hobbies, and interactions with other people, provides valuable information.

Clinicians should ask about the following:

- Frequency and nature of social contacts both in person, via telephone, and online (eg, friends, senior citizens' groups), family visits, and religious or spiritual participation
- Driving and availability of other forms of transportation, including ride-sharing services
- Caregivers and support systems (eg, places of worship, senior citizens' groups, friends, neighbors) that are available to the patient
- The ability of family members to help the patient (eg, their employment status, their health, traveling time to the patient's home)
- The patient's attitude toward family members and their attitude toward the patient (including their level of interest in helping and willingness to help)

Marital status of patients is noted. Questions about sexual practices and satisfaction must be sensitive and tactful but thorough. The number and sex of sex partners are determined, and risk of sexually transmitted infections (STIs) is evaluated. Many sexually active older adults are not aware of the increasing incidence of STIs in older adults and do not follow or even know about safe sex practices.

Patients should be asked about educational level, jobs held, known exposures to toxins, and current and past hobbies. Economic difficulties due to retirement, a fixed income, or death of a spouse or partner are discussed. Financial or health problems may result in loss of a home, social status, or independence.

Advance Directives for the Older Patient

Patient wishes regarding measures for prolonging life must be documented. Patients are asked what provisions for surrogate decision making (advance directives) have been made in case they become incapacitated, and if none have been made, patients are encouraged to make them. Getting patients and their surrogates accustomed to discussing goals of care is important because when circumstances require medical decisions and prior documentation is unavailable or not relevant to the circumstance, which is very common, appropriate decisions can be made.

Key Points

- **Unless corrected, sensory deficits, especially hearing deficits, may interfere with history-taking.**
- **Many disorders in older adults manifest only as functional decline.**
- **As part of the medication history, the patient or a family member should be asked to bring in all the patient's medications, including over-the-counter medications, at the initial visit and periodically thereafter.**
- **Health care professionals must often interview caregivers to obtain the history of functionally dependent older patients.**

More Information

The following English-language resources may be useful. Please note that THE MANUAL is not responsible for the content of these resources.

Medicare: Annual Wellness Examination (AWE): This US resource includes the main components of a comprehensive geriatric assessment and provides a detailed health risk assessment and personalized prevention plan.

Centers for Disease Control and Prevention (CDC): Promoting Health for Older Adults: This web site provides information for older adults, older adults with dementia, and caregivers and information about preventive screening services and other health interventions.