



IMPORTANT
Please return this questionnaire and the deposit in the enclosed envelope by _____. All data must be entered into the computer before the patient's visit. Thank you.

Pre-Visit Questionnaire

Date Completed: _____

Name of person filling out form: _____ Relationship to patient: _____

Patient Name: _____

Address: _____

Phone: (_____) _____ Date of Birth: _____ Age _____

Sex: _____ Male Marital Status: _____ How many years married? _____

_____ Female Spouse Name: _____

Emergency Contact for patient: Name: _____ phone: _____

Address: _____

Email: _____

Name of primary care doctor: _____ Phone _____

Names of other doctors involved in your care (See at least once per year):

Physician Name: _____ Phone: _____

Physician Name: _____ Phone: _____

CONTACT INFORMATION:

List names and relationship of family, friends, and/or caregivers that we can communicate with if needed.

Name: _____ relationship _____

Name: _____ relationship _____

Name: _____ relationship _____

Name: _____ relationship _____

Name: _____ relationship _____

REVIEW OF BODY/ORGAN SYSTEMS: Please circle any symptoms you have had in the past year:

General: Fever/ Sweats/ Fatigue/ Weight gain or Weight loss (___ lbs in ___ months)/ insomnia/ poor appetite

Skin: Rashes/ Jaundice/ Sores or boils/ easy bruising/ blistering/ itching/ insect bites/ animal bites

HEENT: Sore throat/ Cough/ Sinus trouble/ Ear pain or pressure/ Eye pain/ Vision changes/
Trouble with hearing/ Headaches/ toothaches/ difficulty chewing or swallowing

Cardiac: Chest pain/ Chest Pressure/ Shortness of breath with exertion/ Irregular heart rate/
Difficulty breathing when lying down/ Swelling in lower legs or ankles

Lungs: Cough/ Sputum production/ Blood in sputum/ Difficulty breathing/ wheezing

Gastrointestinal: Abdominal pain/ bloating/ heartburn/ difficulty swallowing/
Nausea/ Vomiting/ Diarrhea/ Constipation/ Blood in stool/ Hemorrhoid pain/
Rectal bleeding

Musculoskeletal: Joint pain/Joint stiffness/Joint swelling/ Joint redness/
Bone fractures, if yes where _____

Genitourinary: Pain with urination/difficulty emptying the bladder/bladder urgency/
Incontinence/frequent urination

Neurological: Tremors/ seizures/ dizziness/ fainting/ leg or arm weakness/ memory problems/
hallucinations/ depression, involuntary muscle movements

MEDICAL CONDITIONS YOU HAVE NOW OR HAD IN THE PAST (please check).

I) VISION and HEARING

- A) ___ Cataracts If yes, did you have surgery to remove? _____
B) ___ Glaucoma
C) ___ Macular Degeneration
D) ___ Hearing Loss If YES Do you currently wear a Hearing aid ___ Right ear ___ Left Ear

II) HEART CONDITIONS

- A) ___ Angina E) ___ Irregular Heart rate ___ atrial fibrillation/flutter
B) ___ Heart Attack ___ year F) ___ Other (explain) _____
C) ___ Congestive Heart Failure D) ___ High Blood Pressure

III) LUNG CONDITIONS

- A) ___ Asthma B) ___ Bronchitis ___ Acute (< 6 weeks) ___ Chronic (> 6 weeks) ___ Wears oxygen
C) ___ Pneumonia ___ Year D) ___ COPD/Emphysema E) ___ Other (explain) _____

IV) BONE AND JOINT CONDITIONS

- A) ___ Arthritis B) ___ Bone fractures: if YES list them: _____
C) ___ Gout D) ___ Osteoporosis E) ___ Other _____

V) METABOLIC / NUTRITIONAL CONDITIONS

- A) ___ Diabetes: ___ Insulin is part of treatment ___ medication and diet ___ diet only
- B) ___ Thyroid Disorder ___ Overactive ___ Underactive
- C) ___ Anemia
- D) ___ B12 deficiency
- E) ___ Vitamin D Deficiency
- E) ___ Other (explain) _____

VI) KIDNEY AND URINARY TRACT CONDITIONS

- A) ___ Kidney Infections (Pyelonephritis)
- B) ___ Prostate Disorder ___ Enlarged Prostate ___ Prostate Cancer ___ Surgery
- C) ___ Incontinence of Urine
- D) ___ Frequent Urinary Tract Infections (bladder).
- E) ___ Other (explain) _____

VII) GASTROINTESTINAL CONDITIONS

- A) ___ Gastric Ulcers
- B) ___ Heartburn/ Hiatal Hernia/ Reflux Disease
- C) ___ Diverticulosis
- D) ___ Liver Disease/ Cirrhosis
- E) ___ Colon Polyps
- F) ___ Rectal Bleeding
- G) ___ Persistent diarrhea/constipation
- H) ___ Other _____

VIII.) NERVOUS SYSTEM PROBLEMS

- A) ___ Stroke
- B) ___ Memory loss
- C) ___ Parkinson’s disease
- D) ___ Seizures
- E) ___ Migraine headaches
- F) ___ TIA or mini strokes
- G) ___ Sleep Apnea
- ___ wears CPAP/BiPAP
- H) ___ Bipolar Disorder
- I) ___ Schizophrenia
- J) ___ Depression
- K) ___ Other: _____

IX.) GYNECOLOGY PROBLEMS

- A) ___ Vaginal bleeding (other than periods)
- B) ___ Vaginal discharge
- C) ___ Vaginal itching, burning, pain
- D) ___ Breast lumps or pain

X.) OTHER HEALTH PROBLEMS

- A) ___ Hernia
- B) ___ Sexual Function problems
- C) ___ Blood clots
- D) ___ Cancer where? _____
- E) ___ Other Describe _____

OTHER PAST MEDICAL HISTORY:

Is there a past history of head trauma? _____ If yes, explain: _____

Have you had a scan (MRI or CT) of your **BRAIN**? _____ If yes, date, location, and reason (if known) it was performed?

FAMILY HISTORY OF MEMORY LOSS?

Have any of your first degree relatives (mother, father, siblings or children) been diagnosed with a memory problem? ___yes ___no

If yes, please provide your relationship to the person with the problem and their diagnosis if known:

MEDICATION- please bring all of your medications with you to the appointment for review.

Gather **all** your prescription and non-prescription medicines (pills, eye drops, nasal sprays, ointments, laxatives, herbals, supplements, vitamins, etc.), **everything that you used at least twice in the last year**. Separate those that you use regularly from those that you use only as needed.

List **all** medicine you use **regularly** at this time (prescriptions, herbal remedies, vitamins)

Name of medication used regularly	What strength? (Dose)	How many? How many times per day?

List medicines that you need **“as needed”** at least twice per year.

Medication used “as needed” at least twice in the last year	How often? Daily, weekly, monthly?	What strength?	How many? How many times per day? Reason you take?

ALLERGIES: List any medication allergies AND your reaction to them.

FUNCTIONAL HISTORY:

Please indicate if you need help with any of the following tasks, and who helps you.

TASK	INDEPENDENT	NEEDS ASSISTANCE	NAME & RELATIONSHIP OF PERSON WHO PROVIDES ASSISTANCE
Ambulation			
Bathing			
Dressing			
Toileting			
Transferring (ex: bed to chair)			
Feeding yourself			
Doing housework			
Climbing stairs			
Shopping for groceries			
Cooking			
Taking medications			
Managing finances			
Using the telephone			
Simple home repairs			
Driving			

- I. a) Is someone *employed* in the home to provide care? _____
 b) If so, indicate how many hours a day and how many days a week _____
 c) Does a family member or friend help in the home? _____
 d) If so, indicate how many hours a day and how many days a week _____

- II. a) Do you now drive a car? Yes _____ No _____
 b) During the past week, how many days did you drive? _____
 c) During the past year, have you changed the way you drive? Yes _____ No _____
 If yes, how have you changed? _____
 d) During the past year, have you had any accidents while driving? Yes _____ No _____
 e) During the past year, have you had any near misses while driving? Yes _____ No _____

List OPERATIONS you have had, the month/ year they occurred, and the reason for the surgery.

DATE	OPERATIONS / REASON

List the date of HOSPITALIZATIONS (for anything *other than surgery*) and the reason.

DATE	REASON

HEALTH SCREENINGS

- 1) Have you had a test for blood in your stool? ____ If so, when? _____
- 2) Have you had an examination of your bowel with a scope? (Sigmoidoscopy or Colonoscopy?) _____
If so, when was most recent done? _____
- 3) Have you ever had a shot to prevent pneumonia? ____ If so, when? _____
- 4) Have you ever had a tetanus shot? ____ If so, date of last booster _____
- 5) Have you had a flu shot for current season? _____
- 6) Have you had a shingles vaccination? ____ If so, when? _____
- 7) Have you had a bone density? ____ If so, when? _____

FOR WOMEN ONLY

- 8) Date of last mammogram _____ Do you perform monthly breast self-exams? _____
- 9) Date of last pelvic exam and/or PAP smear _____

FAMILY HISTORY

Please indicate if family members are living or deceased, what illnesses they had, and their age or cause of death.

RELATIVE	LIVING OR DECEASED	AGE	CURRENT ILLNESS OR CAUSE OF DEATH
FATHER			
MOTHER			
SISTER(S)			
BROTHER(S)			
SPOUSE			
CHILDREN			

SOCIAL HISTORY

Where were you born and raised? _____

With whom do you currently live? Names/ages of those in household _____

Describe your residence (house, apt, etc.) _____

Employment status: _____ If retired, age at retirement? _____ Years of schooling? _____

If degree, type of degree? _____

Describe occupations(s) _____

Have you ever served in the military? ___ Yes ___ No

If yes what branch? _____ Dates of Service: _____

Has your spouse ever served in the military? ___ Yes ___ No

If yes what branch? _____ Dates of Service: _____

VA service connected? ___ Yes ___ No if yes self or spouse? _____

Are there firearms in the home? ___ Yes ___ No Ammunition? ___ Yes ___ No

If yes, are they kept in a locked place? ___ Yes ___ No

Are there any pets in the home? ___ Yes ___ No specify: _____

HABITS

Do you use oral tobacco? ___ Yes ___ No Have you ever smoked? ___ Yes ___ No

Are you smoking now? ___ If not, when did you quit? _____

How many years have you smoked? _____ How much do/did you smoke? _____

Do you drink any alcohol? _____ if so, please describe _____

Did you formerly drink alcohol but have now quit? _____ Describe _____

Do you currently participate in any regular activity or exercise program? _____

If so, please describe what activity and how often _____

ADVANCE DIRECTIVES- please bring a copy of these forms with you to the appointment:

Do you have: Living Will ___ No ___ Yes

Health Care Power of Attorney ___ No ___ Yes (Agent Named is _____)

Durable Power of Attorney ___ No ___ Yes (Agent Named is _____)

Medical Order Scope of Treatment form? (MOST form) ___ Yes ___ No

(Out of Hospital) Does Not Resuscitate form? (DNR form) ___ Yes ___ No

Do you have a Long Term Care Insurance policy? ___ Yes ___ No

CURRENT CONCERNS

Do you have any *other* health problems that you would like your doctor to know about before your visit?

What are your goals for this visit?

Resource Assessment

MemoryCare is a non-profit, charitable organization. We rely on the support of grants, foundations, and individual donors, in order to function. Many of the agencies that fund our program require us to provide the following information about families we serve. Your personal identifying information will *never* be shared in association with the information you provide below. Thank you.

The following questions are in reference to the *patient* scheduled to be seen in at MemoryCare.

Number of individuals living in your household: _____ (please include all)

Check yearly household income:

____ (Level 2) Less than \$11,670 ____ (Level 4) \$15,730—23,594 ____ (6) Greater than \$31,460
____ (Level 3) \$11,670—15,729 ____ (Level 5) \$223,595—31,460

Please check if you receive the following sources of income:

Social Security: _____

SSI: _____

Veterans Benefits: _____

Food Stamps: _____

Employment: _____

Medicaid Eligible? ____ yes ____ no

Is Residence:

Owned _____

Rented: _____

Other: (please describe) _____

Please have your insurance cards available for your appointment

THANK YOU FOR COMPLETING THIS FORM

Initials of Care Manager reviewing this form: _____