IMPORTANT
Please return the deposit check and this completed questionnaire in the enclosed envelope by _____. If not received by the above date, we will assume you are not interested. Thank you.

MemoryCare
Quality Time Quality Care

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_____
Name of neurologist: _____Phone_____

Names of other doctors involved in your care (seen at least once per year):
Physician Name: _____ Phone: _____
Physician Name: _____ Phone: _____

Primary Insurance: _____ Member ID#_____Group#_____
Secondary Insurance: _____ Member ID#_____Group#_____

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
B) ____ Heart attack _____ year
C) ____ Congestive heart failure
E) ____ Irregular heart rate ____ atrial fibrillation/flutter
F) ____ Other (explain) _____
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 it most recently 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 test? _____ 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) Do 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 household: _____ (please include all)

Check yearly household income:

____ (Level 2) Less than $12,060 ____ (Level 4) $16,240—24,359 _____ (6) Greater than $32,480
____ (Level 3) $12,060—16,239 ____ (Level 5) $24,360—32,480

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) _____

_____

With which of the following does the patient identify (optional) - please circle one or explain:

African American Alaska Native Asian Caucasian Hispanic/Latino

Native American Other (please specify:_____)

Please have your insurance cards available for your appointment

THANK YOU FOR COMPLETING THIS FORM

Initials of Care Manager reviewing this form: _____