The SECU Center for MemoyCare
100 Far Horizons Ln
Asheville NC 28803-2046
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IMPORTANT
Please return the deposit check and all completed papers in the enclosed envelope by _____. If not received by this date, we will assume you are not interested. Thank you.

PRE-VISIT QUESTIONNAIRE

A family member/caregiver of the person referred is requested to participate in completion of this form using patient data.

Date Completed: _____

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

Patient Name: _____ Last 4 digits of SS#: _____

Address: _____

Phone: (_____) _____ Date of Birth:_____ Age:_____ Gender: □ Male □ Female

Marital Status: _____ How many years married? ____ Spouse Name: _____

Emergency contact for patient: Name: _____ Phone: _____
Address: _____
Email: _____

Primary Insurance: _____ Member ID: _____ Group#: _____
Secondary Insurance: _____ Member ID: _____ Group#: _____
Medicare ID: _____

REVIEW OF BODY/ORGAN SYSTEMS: Please check 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 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 HAVE HAD IN THE PAST (please check):

VISION AND HEARING

□ Cataracts - If YES, did you have surgery to remove them? □ No □ Yes
□ Glaucoma
□ Macular Degeneration
□ Hearing Loss - If YES, do you currently wear a hearing aid? □ Right ear □ Left ear

HEART CONDITIONS

Do you have a pacemaker or defibrillator? □ No □ Yes - If YES, please explain: _____

□ Angina
□ High Blood Pressure
□ Heart Attack**:** Year _____
□ Irregular Heart Rate - □ Atrial Fibrillation/flutter
□ Congestive Heart Failure
□ Other - Please explain**:**_____

LUNG CONDITIONS

□ Asthma
□ Bronchitis**:** □ Acute (<6 weeks) □ Chronic (>6 weeks) □ Wears oxygen
□ Pneumonia**:** Year: _____
□ COPD/Emphysema
□ Other - Please explain**:** _____

BONE AND JOINT CONDITIONS

□ Arthritis
□ Bone Fractures - Please list**:** _____
□ Gout
□ Osteoporosis
□ Other - Please explain**:**_____

METABOLIC/NUTRITIONAL CONDITIONS

□ Diabetes**:** □ Insulin is part of treatment □ Medication and diet □ Diet only
□ Thyroid disorder**:** □ Overactive □ Underactive
□ Anemia □ B12 deficiency □ Vitamin D deficiency □ Other – Please explain**:** _____

KIDNEY AND URINARY TRACT CONDITIONS

□ Kidney infections (Pyelonephritis)
□ Incontinence of urine
□ Prostate disorder**:** □ Enlarged prostate □ Prostate cancer □ Surgery
□ Frequent urinary tract infections (bladder)
□ Other - Please explain**:** _____

GASTROINTESTINAL CONDITIONS

□ Gastric ulcers
□ Colon polyps
□ Heartburn / Hiatal Hernia / Reflux disease
□ Rectal bleeding
□ Diverticulosis
□ Persistent diarrhea/constipation
□ Liver disease / Cirrhosis
□ Other - Please explain**:** _____

NERVOUS SYSTEM PROBLEMS

□ Stroke
□ Migraine headaches
□ Bipolar disorder
□ Memory loss
□ TIA or "mini strokes"
□ Schizophrenia
□ Parkinson's disease
□ Sleep apnea - □ Wears CPAP/BiPAP
□ Depression
□ Seizures
□ Other - Please explain**:**_____

GYNECOLOGY PROBLEMS

□ Vaginal bleeding (other than periods)
□ Vaginal itching, burning, pain
□ Vaginal discharge
□ Breast lumps or pain

OTHER HEALTH PROBLEMS

□ Hernia
□ Blood clots
□ Sexual function problems
□ Cancer - Please explain:_____
□ Other - Please describe**:** _____

OTHER PAST MEDICAL HISTORY:

Is there a past history of head trauma? □ No □ Yes - Please explain: _____

_____

Have you had a scan (MRI or CT) of your **BRAIN**? □ No □ Yes**:** Please list date, location, and reason it was performed (if known).

_____

_____

◄◄Please complete both sides of the form►►

FAMILY HISTORY OF MEMORY LOSS:

Have any of your first degree relatives (mother, father, siblings or children) been diagnosed with a memory problem?
□ No □ Yes - 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, herbal supplements, vitamin supplements, 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, vitamins, and herbal remedies). Attach additional sheet if necessary.

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

List medicines that you take ***"as needed"*** at least twice per year. Attach additional sheet if necessary.

Medication used "as needed" at least twice in the last year	**How often? Daily, weekly, monthly?**	**What strength? (Dose)**	**How many? How many times per day? Reason for taking?**

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

_____
_____

PREFERRED PHARMACY: _____ PHONE:_____

FUNCTIONAL HISTORY

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

Task	Independent	Need Assistance	Name and relationship of person who provides help
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			

Is someone *employed* in the home to provide care? □ No □ Yes - If YES, indicate how many hours a day and how many days a week: _____

Does a family member or friend help in the home? □ No □ Yes - If YES, indicate how many hours a day and how many days a week: _____

DRIVING

Do you now drive a car? □ No □ Yes

If YES, during the past week, how many days did you drive? _____

During the past year, have you changed the way you drive? □ No □ Yes - If YES, how has it changed?

_____

During the past year, have you had any accidents while driving? □ No □ Yes

During the past year, have you had any near misses while driving? □ No □Yes

List any OPERATIONS you have had, the month/year they occurred, and the reason for the surgery. Please attach an additional page if more space is necessary.

Date	Operation/Reason

List any HOSPITALIZATIONS you have had (for anything *other* than surgery), the month/year they occurred, and the reason for the hospitalization. Please attach an additional page if more space is necessary.

Date	Hospitalization/Reason

◄◄Please complete both sides of the form►►

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? Please specify names and ages of those in the household._____

_____

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

Employment status: _____ If retired, at what age did you retire? _____

Years of schooling? _____ If you have a degree, which type? _____

Describe your occupation(s) _____

Have you ever served in the military? □ No □Yes - If YES, which branch? _____
Dates of service:_____

Has your spouse ever served in the military? □ No □ Yes - If YES, which branch? _____
Dates of service: _____

VA service connected? □ No □ Yes - If YES, self or spouse? _____

Are there firearms in the home? □ No □Yes Ammunition? □ No □ Yes
If YES, are they kept in a locked place? □ No □ Yes Specify: _____

Are there any pets in the home? □ No □ Yes Specify: _____

HABITS

Do you currently use oral tobacco? □ No □ Yes

Have you ever smoked? □ No □ Yes

Are you smoking now? □ No □ Yes
If NO, when did you quit? _____
If YES, how many years have you smoked? _____ How much do/did you smoke? _____

Do you drink any alcohol? □ No □ Yes - If YES, describe**:** _____

Did you formerly drink alcohol but have now quit? □ No □ Yes - If YES, describe**:** _____

Do you currently participate in any regular activity or exercise program? □ No □ Yes
If YES, please describe what activity, and how often**:** _____

◄◄Please complete both sides of the form►►

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 Orders for Scope of Treatment Form (MOST form)**:** □ No □ Yes
(Out of Hospital) Do Not Resuscitate form (DNR form)**:** □ No □ Yes

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

CURRENT CONCERNS

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

_____
_____

What are your goals for this visit?

_____
_____

RESOURCE ASSESSMENT

MemoryCare is a community-based, charitable, non-profit organization because of the comprehensive care provided that includes families. 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.** We serve anyone with need. Thank you.

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

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

Check yearly income:

_____ (Level 2) Less than $13,590 _____ (Level 4) $18,311 - $27,465 _____ (Level 6) Greater than $36,620
_____ (Level 3) $13,590 - $18,310 _____ (Level 5) $27,466 - $36,620

Please indicate if you receive the following sources of income:

Social Security: □ No □ Yes SSI: □ No □ Yes Employment: □ No □ Yes
Veterans Benefits: □ No □ Yes Food Stamps: □ No □ Yes Medicaid Eligible: □ No □ Yes

Is your residence:

Owned □ No □ Yes
Rented □ No □ Yes
Other - Please describe**:** _____

With which of the following does the patient identify (optional):

□ African American □ Alaska Native □ Asian □ Caucasian □ Hispanic/Latino
□ Native American □ Other - Please specify**:** _____

Please have all insurance cards, including Medicare, available for your appointment.

THANK YOU FOR COMPLETING THIS FORM