

*Patient Information*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Social Security Number \_\_\_\_\_

Previous name/Nickname \_\_\_\_\_

Physical Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status  Divorced  Partner  Widowed  
 Married  Single  Legally Separated

**Employer Information**

Employer Name \_\_\_\_\_

Employment Status  Employed full-time  Not employed  Retired  
 Employed part-time  Self-employed  Other \_\_\_\_\_

**Emergency Contact**

This person will be contacted by the MD and/or office staff in the event you experience an emergency. The MD and/or office staff may speak to this person regarding your medical care if they were to call our office for information.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Other Phone \_\_\_\_\_

Relationship \_\_\_\_\_

**Primary Insurance Information**

Primary Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

*Patient Information (cont)*

**Primary Insurance Policy Holder Information (if different from patient)**

Please fill out this section only if the primary insurance policy holder is NOT the patient

Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Gender \_\_\_\_\_ Social Security Number \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employment Status  Employed full-time  Not employed  Retired  
 Employed part-time  Self-employed  Other \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance Information**

Secondary Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

*Additional Patient Information*

**Patient Mailing Address (if different than physical address)**

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Ok to leave message at home? Yes No

Residence Type  Independent Living Facility  Group Housing  
 Assisted Living Facility  Home  
 Nursing Home  Homeless  
 Hospice Care Center

**Race and Ethnicity**

Which categories best describe your race?

American Indian or Alaska Native  Black or African American  Other Race  
 Asian  White  Other Pacific Islander  
 Native Hawaiian or Other Pacific Islander  Hispanic  Decline to report race

Which categories best describe your ethnicity-  Hispanic or Latino  Decline to report ethnicity  
 Not Hispanic or Latino

## Additional Patient Information (cont)

### Language Information

What language do you prefer to discuss your healthcare?  English  Spanish  
 Indian  American Sign Language  
 Russian  Other \_\_\_\_\_

Language translation services are available for patients who are not comfortable discussing their healthcare in English during office visits or phone calls. Would you like to use a translator? Yes No

### Pharmacy Information

Local Pharmacy Name \_\_\_\_\_

Local Pharmacy Address/Phone Number \_\_\_\_\_

Mail Order Pharmacy Name \_\_\_\_\_

Mail Order Pharmacy Address/Phone Number \_\_\_\_\_

### Additional Contacts

The MD and/or office staff may speak to these contacts regarding your medical care if they were to call our office for information.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Relationship \_\_\_\_\_

### Patient Care Team

Your care team is defined as the list of all physicians, specialists and healthcare companies providing care to the patient. Your care team can include any specialists, case managers, assisted living facilities, nursing homes, home care services, and durable medical equipment companies that provide you with health care services.

*Additional Patient Information (cont)*

**Patient Care Team**

Please include any current providers, specialists, assisted living facilities, nursing homes, home care services, or durable medical equipment companies

Name	Specialty/Service Provided	Phone

**Additional Information (Structured)**

Advance directives:  Living will  Do Not Resuscitate order  
 Power of attorney  Healthcare surrogate  
 Durable Power of attorney  Healthcare proxy

Please bring a copy of your advance directives with you to your visit.

Are you an organ donor? Yes No

Name of current living facility/residence? \_\_\_\_\_

Please indicate which prescription insurance plan you are currently enrolled in (i.e. Med D):

Plan Name \_\_\_\_\_ ID# \_\_\_\_\_

How did you hear about the Senior Healthcare Center?

- Community agency
- Senior Healthcare Center brochure
- Newspaper
- Relative / friend
- Hospital / referral line
- Yellow pages
- Walked / drove by
- Physician
- Other \_\_\_\_\_

Primary person to contact regarding your care:  Self  Emergency contact  
 Next of kin  Additional contact

## History (HPI) & Assessment

### Chief Complaints

What concerns do you have which you would like discussed during your visit?

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### Activities of Daily Living (ADLs)

Please identify which of the following activities you have difficulty completing and would like further information on regarding available resources for assistance:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Eating                         | <input type="checkbox"/> Preparing meals | <input type="checkbox"/> Taking Medicine |
| <input type="checkbox"/> Dressing                       | <input type="checkbox"/> Driving         | <input type="checkbox"/> Laundry         |
| <input type="checkbox"/> Getting to/from the restroom   | <input type="checkbox"/> Managing money  | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Getting in/out of bed or chair | <input type="checkbox"/> Using telephone |  |
| <input type="checkbox"/> Bathing                        | <input type="checkbox"/> Shopping        |  |
| <input type="checkbox"/> Toileting                      | <input type="checkbox"/> Housekeeping    |  |

### Emotional / Cognitive

Please mark Yes or No to the following questions:

Difficulty remembering things?	Yes	No	Loss of interest in life?	Yes	No
Change in activity level?	Yes	No	Change in sleep patterns?	Yes	No
Feeling sad?	Yes	No	Feeling less able to make decisions?	Yes	No
Feelings of harming yourself or others?	Yes	No	Loss of spouse, family member, or pet?	Yes	No
Feeling anxious?	Yes	No			

### Sleep Patterns

Please select the answer(s) which best describe your sleep pattern:

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Sleep through the night | <input type="checkbox"/> Sleep through the day   | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Take frequent naps      | <input type="checkbox"/> Sleep less than 8 hours |                                      |

Do you experience any of the following sleep disturbances?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Waking up early    | <input type="checkbox"/> Snoring                 |
| <input type="checkbox"/> Continuity disturbances   | <input type="checkbox"/> Daytime drowsiness | <input type="checkbox"/> Wake with a sudden jolt |

### Nutrition

Have you experienced any recent changes in your appetite?

- |                                    |                                    |                                     |
|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Increased | <input type="checkbox"/> Decreased | <input type="checkbox"/> No Changes |
|------------------------------------|------------------------------------|-------------------------------------|

Please select any issues that are affecting your ability to eat.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Difficulty chewing      | <input type="checkbox"/> Problems with dentures     | <input type="checkbox"/> Difficulty understanding or complying with prescribed diet |
| <input type="checkbox"/> Difficulty swallowing   | <input type="checkbox"/> Heartburn                  |   |
| <input type="checkbox"/> Coughing after drinking | <input type="checkbox"/> Inability to taste food    |   |
| <input type="checkbox"/> Coughing after eating   | <input type="checkbox"/> Changes in bowel movements |   |

**OB/GYN (for female patients only)**

Have you ever taken hormone replacement therapy?	Yes	No
Do you lose control of your urine when you laugh or sneeze?	Yes	No
What year did your menstrual cycle stop?	Yes	No
Have you had bleeding since?	Yes	No

**Pain** - Please complete if you are currently suffering from chronic pain:

Pain level when pain is at its **best**: 

Pain level when pain is at its **worst**: 

What treatments are you currently using to manage/treat your pain? \_\_\_\_\_

What is your personal pain goal? 

Where is your pain located? \_\_\_\_\_

How would you describe your pain? (ex. Sharp, burning) \_\_\_\_\_

**Major Life Changes** - Please indicate any major life changes you have recently experienced:

- |  |  |
|--|--|
| <input type="checkbox"/> Death of a child  | <input type="checkbox"/> Divorce                     |
| <input type="checkbox"/> Death of father   | <input type="checkbox"/> Marriage                    |
| <input type="checkbox"/> Death of mother   | <input type="checkbox"/> Separation                  |
| <input type="checkbox"/> Death of spouse   | <input type="checkbox"/> Newly diagnosed diabetic    |
| <input type="checkbox"/> Inability to work | <input type="checkbox"/> Newly diagnosed with cancer |
| <input type="checkbox"/> Lost job          | <input type="checkbox"/> Relocated                   |

**Fall Assessment** - Please select all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Had a fall in the last six months      | <input type="checkbox"/> Using arms to stand up from chair         |
| <input type="checkbox"/> Difficulty walking or standing         | <input type="checkbox"/> Feeling unsteady on feet                  |
| <input type="checkbox"/> Use a cane                             | <input type="checkbox"/> Feeling weak                              |
| <input type="checkbox"/> Use a walker                           | <input type="checkbox"/> Feeling dizzy                             |
| <input type="checkbox"/> Use crutches                           | <input type="checkbox"/> Last eye exam was more than two years ago |
| <input type="checkbox"/> Use a wheelchair                       | <input type="checkbox"/> Hearing worsening with age                |
| <input type="checkbox"/> Need to hold onto things while walking | <input type="checkbox"/> People say you have a hearing problem     |

## *Current Medications*

List all medications you use regularly and how often you take them. **Please include all non-prescription medications such as laxatives, cold tablets, vitamins, herbals, and dietary supplements.** Note: This facility uses an electronic medical record which allows physicians to access a list of prescriptions filled by their patients within the last two years.

**PLEASE BRING ALL MEDICATION BOTTLES WITH YOU TO EACH VISIT**

Medication Name	Dose	Instructions	How long you've been on it

Are you currently receiving Oxygen therapy? Yes          No

If yes, how is it prescribed? \_\_\_\_\_ liters/minute      continuous      intermittent

Which company currently supplies your oxygen? \_\_\_\_\_

### Medical History

Please select any conditions you currently have or have had in the past. Indicate the approximate year next to each.

Condition	Year	Condition	Year	Condition	Year
<input type="checkbox"/> Anemia		<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Drug Addiction		<input type="checkbox"/> Kidney stones	
<input type="checkbox"/> Appetite Change		<input type="checkbox"/> Emphysema		<input type="checkbox"/> Kidney trouble	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Liver disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Gallstones		<input type="checkbox"/> Phlebitis / Blood clots	
<input type="checkbox"/> Bleeding tendency		<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Rheumatic fever	
<input type="checkbox"/> Blood transfusion		<input type="checkbox"/> Gonorrhea		<input type="checkbox"/> Syphilis	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Gout		<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Chest pain		<input type="checkbox"/> Heart murmur		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Colitis		<input type="checkbox"/> Heart trouble		<input type="checkbox"/> Yellow jaundice	
<input type="checkbox"/> Depression		<input type="checkbox"/> Hemorrhoids			
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Hepatitis			

### Procedure History

Please select any procedures you have had in the past and indicate the approximate year:

Procedure	Year	Procedure	Year
<input type="checkbox"/> Chest x-ray		<input type="checkbox"/> Bone density scan	
<input type="checkbox"/> Other x-ray		<input type="checkbox"/> Pap smear / pelvic exam	
<input type="checkbox"/> Mammogram		<input type="checkbox"/> Breast exam	
<input type="checkbox"/> Echocardiogram		<input type="checkbox"/> Flexible sigmoidoscopy	
<input type="checkbox"/> EKG		<input type="checkbox"/> Colonoscopy	
<input type="checkbox"/> Nuclear stress test		<input type="checkbox"/> Prostate exam	

### Allergy History

List allergies and the type of reaction you had when exposed to the allergen. Please include allergies to medications and non-medication allergies including foods, iodine, radiology IV dyes and contrast, and latex products.

Medication/Food/Misc agent/Substance	Reaction



## Surgical History and Hospitalizations

List any surgeries and hospitalizations you have had in the past starting with the most recent

Year	Operation or Illness	Hospital	City/State

## Family History

Relation	Age	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Cause of death
Father		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sisters(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Son(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daughter(s)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## Social History

### Veteran Status

Are you a veteran?    Yes                      No

Are you a surviving spouse of a veteran?    Yes                      No

### Occupation

Occupation/Type of Work \_\_\_\_\_ Date last worked \_\_\_\_\_

### Learning Status

What is your preferred method of learning?     Demonstration                       Written instructions  
 Verbal instructions                       Other \_\_\_\_\_  
 Self-study pamphlet

Highest grade completed in school     Did not finish high school     Did not finish college  
 GED     College  
 High school                                       Masters/PhD

Persons required during education     No other person required     Caregiver  
 Significant other                               friend  
 Family member

Check if you are     Hearing impaired                       Visually impaired

*Social History (cont)*

Do you have any medical conditions and/or memory difficulties which may affect your ability to learn? Yes No

If yes, please explain \_\_\_\_\_

Do you have any religious or cultural restrictions which may affect your ability to learn or treatment? Yes No

If yes, please explain \_\_\_\_\_

Literary Status Able to read/write Unable to read/

**Household**

Number of adults in your current household \_\_\_\_\_

You are a caregiver for Spouse Child  
Parent Oth-

You currently live with Child/children Parents  
Family Self  
Father Sibling  
Friend Spouse  
Mother Other \_\_\_\_\_

**Activities of Daily Living**

Please check all activities which you currently receive assistance with

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bathing                        | <input type="checkbox"/> Housekeeping    | <input type="checkbox"/> Taking medicine      |
| <input type="checkbox"/> Dressing                       | <input type="checkbox"/> Laundry         | <input type="checkbox"/> To and from bathroom |
| <input type="checkbox"/> Driving                        | <input type="checkbox"/> Managing money  | <input type="checkbox"/> Toileting            |
| <input type="checkbox"/> Eating                         | <input type="checkbox"/> Preparing meals | <input type="checkbox"/> Using telephone      |
| <input type="checkbox"/> Getting in/out of bed or chair | <input type="checkbox"/> Shopping        | <input type="checkbox"/> Other _____          |

Please select which services you are currently receiving

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Hospice care | <input type="checkbox"/> Medical alert service | <input type="checkbox"/> Transportation assistance |
| <input type="checkbox"/> Home care    | <input type="checkbox"/> Meals on wheels       | <input type="checkbox"/> Other _____               |

Please list the name(s) of the company providing services \_\_\_\_\_

Please indicate if you are Bedridden Using a prosthesis  
Using a cane Using a walker  
Using a crutch Using a wheelchair

## Social History

### History

Please select if you have a history of or been diagnosed with/as

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Clinical depression | <input type="checkbox"/> Alcohol addiction | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Depression          | <input type="checkbox"/> Schizophrenia     | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Bipolar  | <input type="checkbox"/> Drug addiction      | <input type="checkbox"/> Sleeping disorder |  |
| <input type="checkbox"/> Bulimia  | <input type="checkbox"/> Emotional disorder  | <input type="checkbox"/> Suicidal          |  |

Previously under the treatment of  Counselor  Psychiatrist  Psychologist

Currently under the treatment of  Counselor  Psychiatrist  Psychologist

### Nutrition

Please indicate any special diets you are currently on. Select all that apply.

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Regular              | <input type="checkbox"/> Low calorie          | <input type="checkbox"/> Mechanical soft | <input type="checkbox"/> No strawberries |
| <input type="checkbox"/> ADA                  | <input type="checkbox"/> Low cholesterol      | <input type="checkbox"/> No dairy        | <input type="checkbox"/> No tomatoes     |
| <input type="checkbox"/> Enteral tube feeding | <input type="checkbox"/> Low fat              | <input type="checkbox"/> No red meats    | <input type="checkbox"/> Pureed foods    |
| <input type="checkbox"/> Kosher               | <input type="checkbox"/> Low/no carbohydrates | <input type="checkbox"/> No seeds        | <input type="checkbox"/> TPN             |
| <input type="checkbox"/> Liquid               | <input type="checkbox"/> Low salt             | <input type="checkbox"/> No shellfish    | <input type="checkbox"/> Vegetarian      |

Length of time on diet(s) selected above \_\_\_\_\_

What was your weight at age 20? \_\_\_\_\_ lbs

What was your weight one year ago? \_\_\_\_\_ lbs

What is your normal eating pattern?  Eat three meals per day  Skip a meal every day  
 Snack throughout the day  Other \_\_\_\_\_

### Tobacco Product Screening

Are you a  Current smoker  Former smoker  Never smoker  
 Current everyday smoker  Occasional smoker

### Current and Former Smokers Only

Are you interested in quitting?  Ready to quit  Not ready to quit  
 Thinking about quitting

How many cigarettes a day do you smoke?  5 or less  11 - 20  31 or more  
 6 - 10  21 - 30

How soon after you wake up do you smoke your first cigarette?  Within 5 min  31 - 60 min  
 6 - 30 min  After 60 min

If you are a former smoker, how long has it been since you last smoked?

- |  |  |                                       |   |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> Less than 1 month | <input type="checkbox"/> 3 - 6 months  | <input type="checkbox"/> 1 - 5 years  | <input type="checkbox"/> More than 10 years |
| <input type="checkbox"/> 1 - 3 months      | <input type="checkbox"/> 6 - 12 months | <input type="checkbox"/> 5 - 10 years |   |

What type of tobacco products?  Cigarettes  Cigars  Pipes  Smokeless tobacco

How long have you used tobacco products? \_\_\_\_\_

*Social History (cont)*

**Alcohol Screening**

Have you had a drink containing alcohol in the past year? Yes No

**If you've had a drink containing alcohol in the past year, please answer the following questions.**

How often did you have a drink containing alcohol in the past year?

- Never
- Monthly or less
- 2 to 4 times a month
- 2-3 times a week
- 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

How often did you have six or more drinks on one occasion in the past year?

- Never
- Monthly
- Daily or almost daily
- Less than monthly
- Weekly

What is the most common type of alcoholic beverage you drink? \_\_\_\_\_

**Caffeine**

Please check the appropriate answer regarding your caffeine intake

- Do not use
- 1 cup/glass per day
- 2 cups/glasses per day
- 3 cups/glasses per day
- 4 cups/glasses per day
- 5 cups/glasses per day
- > 5 cups/glasses per day

**Exercise**

Please check the appropriate answer(s) regarding your exercise activity

- Do not exercise regularly
- Cycle
- Run
- Tai chi
- Yoga
- Walk
- Weight lift
- Other \_\_\_\_\_

I exercise:  1  2  3  4  5  >5 time(s) per  Day  Week  Month

**Immunizations**

Please enter the date of the last immunization

Immunization	Date	Immunization	Date
Influenza		TD Tetanus Diphtheria	
Prevnar-13 (Pneumococcal)		TDap Tetanus (Pertussis)	
Pneumovax-23 (Pneumococcal)		Zostavax (Shingles)	

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date