

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 Relative / friend Physician
 Senior Healthcare Center brochure Hospital / referral line Other _____
 Newspaper Yellow pages
 Walked / drove by

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?

Activities of Daily Living

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"/> Bathing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Use crutches |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Walking | <input type="checkbox"/> Use a wheelchair |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Use a cane | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Grooming | <input type="checkbox"/> Use a scooter | |
| <input type="checkbox"/> Oral Care | <input type="checkbox"/> Use a walker | |

Instrumental Activities of Daily Living

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"/> Driving | <input type="checkbox"/> Preparing Meals | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Shopping | |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Taking Medications | |
| <input type="checkbox"/> Managing Money | <input type="checkbox"/> Using a Telephone | |

Cognitive

Please mark Yes or No to the following question:

Difficulty remembering things? Yes No

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

- | | |
|--|--|
| <input type="checkbox"/> Death of a child | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Death of a parent | <input type="checkbox"/> Newly diagnosed with diabetes |
| <input type="checkbox"/> Death of a pet | <input type="checkbox"/> Newly diagnosed with cancer |
| <input type="checkbox"/> Death of spouse/significant other | <input type="checkbox"/> Relocated |
| <input type="checkbox"/> Inability to work | |
| <input type="checkbox"/> Recent job loss | |
| <input type="checkbox"/> Divorce | |
| <input type="checkbox"/> Marriage | |

Fall Assessment - Please select all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Had a fall in the last six months | <input type="checkbox"/> Difficulty walking or standing |
|--|---|

Nutrition

Have you experienced any recent changes in your appetite?

- | | | |
|-------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> No changes | <input type="checkbox"/> Increase | <input type="checkbox"/> Decrease |
|-------------------------------------|-----------------------------------|-----------------------------------|

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 complying or understanding 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 to bowel movements | |

History (HPI) & Assessment (cont)

Sleep Patterns

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

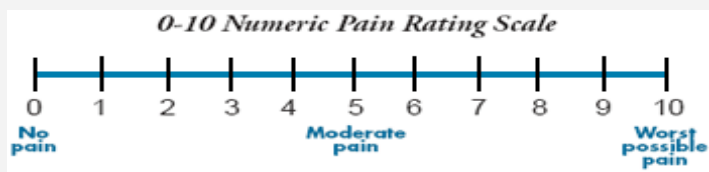
- Sleeping through the night
 Taking frequent naps
 Sleeping through the day
 Sleeping less than 8 hours

Do you experience any of the following sleep disturbances?

- Difficulty falling asleep
 Daytime drowsiness
 Waking for frequent urination
 Continuity disturbances
 Snoring
 Restlessness throughout sleep
 Waking up early
 Waking with a sudden jolt

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

Pain level on a scale of 1 to 10:



Pain Location: _____

Pain characteristics:

- Aching
 Piercing
 Sharp
 Stabbing
 Throbbing
 Episodic
 Other _____

Modifying Factors:

- Advil
 Aspirin
 Elevation
 Heat
 Ice
 Prescribed pain medications
 Rest
 Tylenol
 Other _____

Pain Duration:

- Less than a week
 One week
 Two weeks
 Three weeks
 One month
 Over a month

Episode Frequency:

- All Day
 In the morning
 In the evening
 Other _____

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

Have you had bleeding since the stop of your menstrual? Yes No

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"/> Osteoporosis	
<input type="checkbox"/> Bleeding tendency		<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Phlebitis / Blood clots	
<input type="checkbox"/> Blood transfusion		<input type="checkbox"/> Gonorrhea		<input type="checkbox"/> Rheumatic fever	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Gout		<input type="checkbox"/> Syphilis	
<input type="checkbox"/> Chest pain		<input type="checkbox"/> Heart murmur		<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Colitis		<input type="checkbox"/> Heart trouble		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Depression		<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Yellow jaundice	
<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 _____

Illicit Drug Use

Have you ever used illicit drugs? Yes No

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 _____

Please select which services you are currently receiving

Hospice care Medical alert service Transportation assistance
Home care Meals on wheels 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

Dietary Assessment

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