UNC GERIATRIC SPECIALTY CLINIC

Welcome to our clinic!
We look forward to becoming involved in your care.
Please fill out as much as you can of the packet and either mail it back or bring it to your first appointment.
Thank you!

Name: _____ DOB: _____

Who has been your primary care doctor?
Name _____
Address _____
Phone # _____
Do you plan to continue care with your primary care doctor after establishing care with us?
☐ Yes ☐ No ☐ Not sure

What other doctors do you see? Please list name, specialty, and location (name of clinic practice or city).

1.

2.

3.

Please list any specific concerns you would like your doctor to address at your first visit.

4.

5.

6.

CURRENT MEDICATIONS

Please include all medications and supplements.
You can also bring your own list of medications or a bag of your medications to the visit.

What is your preferred pharmacy?
Name
Address

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

ALLERGIES

□ No Known Allergies

Allergen	Reaction

PAST MEDICAL HISTORY (Please check all that apply.)

EYE & EAR
□ Macular degeneration
□ Cataracts
□ Glaucoma
□ Hearing loss / Hearing aid
□ Other:

HEART
□ Heart attack
□ Heart failure
□ High blood pressure
□ Aortic stenosis
□ Heart valve problem
□ Angina
□ High cholesterol
□ Pacemaker
□ Atrial fibrillation
□ Irregular heartbeats (arrhythmias)
□ Other:

GASTROINTESTINAL TRACT
□ Heartburn / reflux / GERD
□ Ulcers
□ Irritable bowel
□ Liver disease / cirrhosis
□ Hepatitis
□ Gallbladder disease
□ Colon polyps
□ Diverticulosis
□ Bleeding problems
□ Constipation
□ Hemorrhoids
□ Fecal incontinence
□ Other

KIDNEY & URINARY TRACT
□ Frequent bladder infections

□ Kidney disease
□ Enlarged prostate
□ Urinary incontinence
□ Kidney stones
□ Other:

BONES & JOINTS
□ Gout
□ Low back pain
□ Osteoporosis
□ Arthritis:
  □ Hip
  □ Knee
  □ Shoulder
  □ Back
  □ Hand
  □ Other:
□ Fractured bone:
  □ Hip
  □ Spine
  □ Wrist
  □ Other:
□ Other:

GLANDS
□ Thyroid overactive (high)
□ Thyroid underactive (low)
□ Diabetes
□ Other:

NERVOUS SYSTEM
□ Dementia or Alzheimer's disease
□ Parkinson's disease
□ Stroke
□ Epilepsy or seizures
□ Neuropathy / nerve damage
□ Depression
□ Anxiety
□ Other:

LUNGS
□ Asthma
□ COPD / emphysema
□ Bronchitis
□ Frequent pneumonias
□ Other:

OTHER HEALTH PROBLEMS
□ Blood clots:
□ Syncope (loss of consciousness)
□ Hernia
□ Anemia
□ Cancer:
  □ Breast
  □ Prostate
  □ Colon / rectum
  □ Lung
  □ Skin
  □ Lymphoma / leukemia
  □ Other: _____

PAST SURGICAL HISTORY

Type of Surgery (Operation)	Year (approximately)

FAMILY HISTORY

Are there illnesses that tend to run in your family (e.g., cancer, high blood pressure, diabetes)?

Who in your family has had Alzheimer's disease or other types of dementia?

SOCIAL HISTORY

What is the highest level of schooling / education that you completed?

What do/did you do for a living?

What else should we know about you (where you were born, where you have lived, hobbies/interests, etc.)

How much alcohol do you drink (wine, beer, or liquor)?

☐ Daily ☐ 1-3 times per/week □ Less than 1 time/week □ None

How many drinks do you usually have at one time? _____ drinks
One standard drink is 1.5 ounces of liquor, 12 ounces of beer, or 4 ounces of wine.

Have you ever smoked cigarettes or cigars? ☐ Yes ☐ No

If yes, are you still smoking? ☐ Yes ☐ No

How many years did/have you smoked? _____ years

How many packs of cigarettes per day?

Have you ever used chewing tobacco? ☐ Yes ☐ No

Do you need the help of another person to do any of these activities?

Eating ☐ Never ☐ Sometimes □ All the time
Dressing ☐ Never ☐ Sometimes □ All the time
Walking ☐ Never ☐ Sometimes □ All the time
Toileting ☐ Never ☐ Sometimes □ All the time
Bathing ☐ Never ☐ Sometimes □ All the time
Using the phone ☐ Never ☐ Sometimes □ All the time
Shopping ☐ Never ☐ Sometimes □ All the time

Meal preparation ☐ Never ☐ Sometimes □ All the time

Managing your medicines ☐ Never ☐ Sometimes □ All the time

Managing finances ☐ Never ☐ Sometimes □ All the time

Housework ☐ Never ☐ Sometimes □ All the time

Transportation ☐ Never ☐ Sometimes □ All the time

Do you currently drive a car? □ Yes □ No

Do you have any issues with:

Memory □ Yes □ No

Vision □ Yes □ No

Hearing □ Yes □ No

Swallowing □ Yes □ No

Sleep □ Yes □ No

Urinary leaking/incontinence □ Yes □ No

Stool leaking/incontinence □ Yes □ No

Where do you live? (e.g., own home, assisted living, etc)

Who lives with you?

Have you lost weight without trying in the last 6 months? □ Yes □ No

If you checked yes, how much? lbs

In the last month, have you had too little energy to do the things you want to do? □ Yes □ No

How often do you engage in tough activities such as gardening, cleaning the car, or going for a walk?

□ once a week

□ one to three times a month

□ hardly ever or never

MOBILITY

1.) Are you afraid of falling? □ Yes □ No
2.) Have you had at >1 fall in the last 6 months, causing injury? □ Yes □ No
3.) Have you had a >2 falls in the past year? □ Yes □ No
4.) Do you use any walking aid, such as a cane or walker? □ Yes □ No If yes, what kind?

MOOD

We care about your overall well-being. Over the past two weeks, how often have you been bothered by:

Little interest or pleasure in doing things	**Feeling down, depressed or hopeless**
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

ADVANCE DIRECTIVES

If you have any of these forms, please bring a copy of them to your appointment.

If you were too sick to share your care preferences, who would help you make your healthcare decisions?

Name: Relationship: Contact:

Do you have a Durable Power of Attorney for Health Care (DPOA)? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Do you have a DNR (Do Not Resuscitate) gold form? ☐ Yes ☐ No

Do you have a North Carolina MOST form (pink)? ☐ Yes ☐ No

HEALTH MAINTENANCE

To the best of your knowledge, when and where did you last have the following immunizations, examinations, and tests? Not every test or vaccine is needed for every person..

Health maintenance item	**Where?**	**Approximately when?**	**Any issues or abnormalities**
COVID-19 (please list all boosters)			
Pneumonia shot: Pneumovax (PPSV23)			
Pneumonia shot: Prevnar (PCV-13)			
Pneumonia shot: Prevnar 20			
Tetanus booster shot (Td or Tdap)			
Shingles shot (Zostavax or Shingrix) *Shingrix is a 2 shot series starting in 2015			
Flu shot (most recent)			
Colonoscopy or stool test for colon cancer			
Bone density test (DEXA)			
Pap smear (women)			
Mammogram (women)			
Other test			