UNC GERIATRIC SPECIALTY CLINIC

Welcome to our clinic!
We look forward to becoming involved in your care.
Please complete this questionnaire and either mail it back or bring it to your first appointment. Thank you.

Name: _____ DOB: _____ AGE: ____ Sex: □ M □ F

If you are not the patient filling out this form, what is your name and relationship to the patient?

Name: _____ Phone Number: _____

□ Spouse □ Child □ Friend □ Other: _____

What is your preferred pharmacy?

Name _____

Address _____

Phone # _____

Who has been your primary care doctor?

Name _____

Address _____

Phone # _____

Do you plan to continue seeing that primary care doctor?

□ Yes □ No □ Not sure

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

_____

_____

_____

_____

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

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICATIONS

Please include all vitamins and supplements ****You may bring own list to visit if you prefer***
Please include aspirin if you take it every day.

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

ALLERGIES

□ No Known Allergies □ Latex allergy

Allergy	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
□ Other _____

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

OTHER HEALTH PROBLEMS
□ Blood clots:
  □ Leg
  □ Lung
□ 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?

Whom in your family has had cancer? What kind of cancer?

Whom in your family has had dementia or Alzheimer's disease?

SOCIAL HISTORY

Where do you live? _____

Who lives with you? _____

Marital Status: ☐ Single ☐ Significant Other ☐ Married ☐ Divorced ☐ Widowed/Widower, since: _____

Name of spouse/significant other: _____

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

What do/did you do for a living? _____

Do you do any physical activity? _____

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

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

Walking ☐ Yes ☐ No

Eating ☐ Yes ☐ No

Bathing ☐ Yes ☐ No

Dressing ☐ Yes ☐ No

Grooming (brushing teeth, shaving, etc.) ☐ Yes ☐ No

Using the toilet ☐ Yes ☐ No

Using the telephone ☐ Yes ☐ No

Shopping ☐ Yes ☐ No

Preparing meals ☐ Yes ☐ No

Doing laundry ☐ Yes ☐ No

Housekeeping ☐ Yes ☐ No

Taking medications ☐ Yes ☐ No

Handling finances / paying bills ☐ Yes ☐ No

Comments on any of these? _____

_____

Do you currently drive a car? ☐ Yes ☐ No

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

CHILDREN ☐ Yes ☐ No Deceased?

Name: _____ Age: _____ Location: _____ ☐Yes ☐No

Name: _____ Age: _____ Location: _____ ☐Yes ☐No

Name: _____ Age: _____ Location: _____ ☐Yes ☐No

Name: _____ Age: _____ Location: _____ ☐Yes ☐No

Name: _____ Age: _____ Location: _____ ☐Yes ☐No

ADVANCE DIRECTIVES

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

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) form? ☐ Yes ☐ No

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

HEALTH MAINTENANCE

To the best of your knowledge, when and where did you last have the following immunizations, examinations, and tests? Approximate dates and locations are fine.

Health maintenance item	Where?	When? (most recent)	Any issues or abnormalities?
Pneumonia shot: Pneumovax (PPSV23)			
Pneumonia shot: Prevnar (PCV-13, available since 2010)			
Shingles shot: Zostavax (available since 2006)			
Shingles shot: Shingrix (available since 2017)			
Tetanus shot			
Flu shot			
Colonoscopy or stool test for colon cancer			
Mammogram (women)			
Pap smear (women)			
Bone density test (DEXA scan)			
Eye exam			
Hearing test			
Other test			

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 ☐ Several days ☐ More than half the days ☐ Nearly every day	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

MOBILITY

1.) Are you afraid of falling? ☐ Yes ☐ No

2.) Have you had a fall in the past year? ☐ Yes ☐ No

3.) Do you use any walking aid, such as a cane or walker? ☐ Yes ☐ No

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Other: _____

MEMORY

1.) Do you feel you have problems with memory? ☐ Yes ☐ No

2.) Is anyone else in your life concerned about your memory? ☐ Yes ☐ No

3.) Would you like to speak to the doctor privately about memory or behavior concerns? ☐ Yes ☐ No

Thank you for taking the time to complete this form!