Atrium Health

Senior Care
101 E W.T. Harris Boulevard, Bldg. 1000, Ste. 1110
Charlotte NC 28262
P: 704-863-9850
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Person Completing This Form: _____

Patient Name: _____ **Patient DOB:** _____

SOCIAL HISTORY OF PATIENT

Gender/Identification: □Male □Female □Other _____

Status: □Single □Married (# of Years): _____ □Divorced (# of Years): _____ □Widowed (# of Years): _____

Name of Spouse/Significant Other: _____ Number of Children: _____

Names of Child(ren) or Caregiver(s) involved in Care:

Name:	Relationship:	Location (city/town):	Phone Number:

Do you have a Durable Power of Attorney? _____ If Yes, please name: _____

Do you have a HealthCare Power of Attorney? ____ If Yes, please name: _____

Education: Highest level completed: _____

Profession: What type of work do/did you do? _____

Hobbies: what do you enjoy doing: _____

Where do you live? □House □Apartment □Other (Assisted Living/Independent Living/Retirement Community)

If Other, list name and phone number of the facility: _____

Special Services: □Home Health □Private Aide □Meal Delivery □Other_____

Do you smoke? □No □Yes If Yes, how many years have you smoked? _____ How many per day (number/packs) _____

Have you ever smoked? □No □Yes If yes, for how many years? _____ When did you quit? _____

Do you drink alcohol? □No □Yes If Yes, what type_____How many drinks per week? _____

Do you have a history of excessive or problem drinking? □No □Yes

Do you use any recreational/non-prescription drugs? □No □Yes

Do you have guns in the home? □No □Yes, if Yes, are they locked and secured? □No □Yes

Do you exercise? □No □Yes If Yes, what type and how often? _____

FAMILY HEALTH HISTORY

Has anyone in the family been diagnosed with dementia? □No □Yes

If Yes, please list relationship to you, and the age of onset? _____

Patient Name: _____ **Patient DOB:** _____

What is the main reason for this visit?

_____

_____

_____

_____

_____

_____

_____

List the questions or concerns that you would like to discuss today:

1)_____

2)_____

3)_____

4)_____

5)_____

Have you been evaluated in the Emergency Department in the past six (6) months? □No □Yes

If Yes, please list location(s) and approximate date(s):

1)_____

2)_____

3)_____

4)_____

Have you been admitted/hospitalized in the past six (6) months? □No □Yes

If Yes, please list Hospital(s) and approximate date(s):

1)_____

2)_____

3)_____

4)_____

Patient Name: _____ **Patient DOB:** _____

MEMORY QUESTIONNAIRE: Please complete this form with a family member

DO YOU HAVE PROBLEMS WITH:

Please check the appropriate box

ORIENTATION TO TIME	Yes	No
1. Day of the month	□	□
2. Day of the week	□	□
3. Time of day	□	□
4. Year	□	□

MEMORY	Yes	No
1. Recalling recent events	□	□
2. Remembering where things are in the home	□	□
3. Need written lists for everything	□	□
4. Remembering appointments	□	□
5. Learning new things	□	□
6. Remembering new information	□	□
7. Remembering family events (birthdays)	□	□
8. Remembering names of friends / family	□	□
9. Recognize friends / family (faces, names)	□	□
10. Confusion about family members (alive/dead)	□	□

SPEECH	Yes	No
1. Finding words	□	□
2. Speaking clearly (understandability)	□	□
3. Following directions	□	□
4. Reading	□	□
5. Writing	□	□
6. Change in quality of speech + /-	□	□

THINKING	Yes	No
1. Finances (paying bills, balancing checkbook)	□	□
2. Financial decisions: poor choices	□	□
3. Leisure activities (hobbies, games, socializing)	□	□

SENSE OF DIRECTION	Yes	No
1. Getting lost driving	□	□
2. Getting lost in the neighborhood	□	□
3. Getting lost in your home	□	□
4. Getting your clothes arranged	□	□

HAVE YOU EXPEREINCED:

Please check the appropriate box

	Yes	No
1. Have you had any recent falls?	□	□
2. Do you have a fear of falling?	□	□
3. Do you have food insecurity/scarcity?	□	□
4. Housing insecurity?	□	□
5. Do you have access to transportation?	□	□
6. Do you feel safe at home?	□	□

CHANGE IN FEELINGS/ACTIVITY	Yes	No
1. Sleep	□	□
2. Guilt / worthlessness	□	□
3. Energy	□	□
4. Sadness / crying	□	□
5. Loss of appetite	□	□
6. Slowness in movements	□	□
7. Very restless / agitated	□	□
8. Suicide thoughts	□	□
8. History of depression	□	□

ACTIVITY CHANGES	Yes	No
1. Starting tasks	□	□
2. Completing tasks	□	□
3. Trouble with concentration	□	□

OTHER PROBLEMS	Yes	No
1. Paranoid	□	□
2. Fearful	□	□
3. Loss of confidence	□	□
4. Irritable	□	□
5. Hallucinations (things or people who aren't there)	□	□
6. Inappropriate laughing or crying	□	□
7. Impolite, embarrassing comments to others	□	□
8. Physical / verbal aggression	□	□
9. Confusion – disoriented	□	□
10. Mood swings	□	□
11. Repetitive actions (sorting, wandering, muttering)	□	□

Patient Name: _____ **Patient DOB:** _____

FUNCTIONAL STATUS: *Please check the appropriate box*

Activities of Daily Living	NO Assistance	WITH Assistance
Bathing	□	□
Dressing	□	□
Toileting	□	□
Continence	□	□
Feeding	□	□
Transferring / Walking	□	□

Do you use a □Cane □Wheelchair □Walker □Rollator

Instrumental Activities of Daily Living	NO Assistance	WITH Assistance
Using Telephone	□	□
Grocery Shopping	□	□
Preparing Meals	□	□
Doing Housework	□	□
Doing Laundry	□	□
Taking Medications	□	□
Managing Finances	□	□
Driving	□	□

COMMENTS_____

_____

_____

_____

PLEASE CHECK THE BOXES THAT APPLY TO YOU

GENERAL	Yes	No
1. Weight change	□	□
2. Appetite or thirst change	□	□
3. Excessive fatigue or nervousness	□	□
4. Difficulty sleeping	□	□
5. Other_____	□	□

EYES	Yes	No
1. Do you wear glasses or contacts	□	□
2. Vision changes	□	□
3. Other _____	□	□

EARS	Yes	No
1. Hearing loss	□	□
2. Buzzing or ringing	□	□
3. Feel "stopped up"	□	□
4. Other _____	□	□

NOSE AND THROAT	Yes	No
1. Teeth or Gum problems	□	□
2. Change in taste	□	□
3. Sleep apnea (stop breathing while sleeping)	□	□
4. Snoring	□	□
5. Other _____	□	□

CARDIOVASCULAR	Yes	No
1. Chest pain or tightness	□	□
2. Irregular heartbeat	□	□
3. High blood pressure	□	□
4. Swelling of feet ankles	□	□
5. Leg cramps with walking	□	□

GASTROINTESTINAL	Yes	No
1. Difficulty swallowing	□	□
2. Stomach pains or ulcers	□	□
3. Nausea or vomiting	□	□
4. Loose stools or diarrhea	□	□
5. Constipation	□	□
6. Frequent laxative use	□	□
7. Bowel incontinence	□	□

URINARY	Yes	No
1. Incontinence (wetting)	□	□
2. Other _____	□	□

PULMONARY	Yes	No
1. Shortness of breath or difficulty breathing	□	□
2. Other _____	□	□

MUSCULOSKELETAL	Yes	No
1. Weakness	□	□
2. Prone to falls	□	□
3. Falls	□	□
5. Other _____	□	□

SKIN	Yes	No
1. Rashes	□	□
2. Dry or itchy skin	□	□
3. Bruising	□	□
4. Sweats	□	□
5. Other _____	□	□

NEUROLOGIC	Yes	No
1. Headaches	□	□
2. Dizziness or lightheadedness	□	□
3. Fainting or blackouts	□	□
4. Numbness or tingling	□	□
5. Tremors	□	□
6. Seizures or convulsions	□	□
7. Memory loss	□	□
8. Coordination or balance problems	□	□
9. Other _____	□	□