Senior Care
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Charlotte, NC 28262
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Atrium Health

Person Completing This Form: _____

Name: _____ DOB: _____

Social History

Where were you born? _____

Are you:

Single: _____Married (# Years): _____ Divorced (# Years): _____Widowed (# Years):_____

Number of Children _____

Children's Names:	Location (town):	Phone:

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

Do you have a Living Will / Advanced Directives?_____ If yes, who is listed as Health Care Agent? _____

Please provide us a copy of Living Will for our records.

How many years of education have you completed?_____

Occupation now or before retiring: _____

Hobbies / activities? _____

Are there services in the home? _____

(Home Health, Private Aide, Meals on Wheels)

_____

Do you smoke?____ Yes ___ No If YES, how many years have you smoked?_____

How many packs per day do you smoke?_____

Have you ever smoked? ____ Yes ___ No If YES: when did you quit_____how many years did you smoke? _____

Do you drink alcohol?____ Yes____ No What type_____ How much a day _____

Do you have a history of excessive or problem drinking?_____

Do you have guns in the home?_____

Family Health History

Is your mother living?_____ Age at death? _____List your mother's medical problems:_____

Is your father living?_____ Age at death? _____List your father's medical problems: _____

How many brothers do you have?_____Any medical problems? _____

How many sisters do you have?_____Any medical problems? _____

How many sons do you have?_____Any medical problems? _____

How many daughters do you have?_____Any medical problems? _____

Has anyone in the family been diagnosed with Dementia? _____

Physician or other person who referred patient to this office: _____

Name: _____ DOB: _____

What is the main reason for this visit:

_____

_____

_____

_____

_____

_____

_____

List the major issues you would like to discuss today:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Are there any other healthcare professionals helping you with these problems? If Yes, who?

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

IF prior interventions / medications failed, why?

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

MEDICATION LIST *(Prescriptions and Over-The-Counter)*

Name: _____ DOB: _____

Name of Medication	Dose	How often is it taken	Approximate Date Started	Reason you take this medication

Medication Allergies *(and reactions):*

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

Name: _____ DOB: _____

MEMORY QUESTIONNAIRE: Please complete this form with a family member.

DO YOU HAVE PROBLEMS WITH:

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

MEMORY		
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)	☐	☐
10. Confusion about family members (who is alive / dead)	☐	☐

SPEECH		
1. Finding words	☐	☐
2. Speaking clearly (understandability)	☐	☐
3. Following directions	☐	☐
4. Reading	☐	☐
5. Writing	☐	☐
6. Change in quality of speech + / -	☐	☐

THINKING		
1. Finances (paying bills, balance checkbook)	☐	☐
2. Financial decisions: poor choices	☐	☐
3. Leisure activities (hobbies, games, socializing)	☐	☐

SENSE OF DIRECTION		
1. Getting lost driving	☐	☐
2. Getting lost in the neighborhood	☐	☐
3. Getting lost in your home	☐	☐
4. Getting your clothes arranged	☐	☐

HAVE YOU EXPERIENCED:

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	☐	☐s
8. History of depression	☐	☐

ACTIVITY CHANGES		
1. Start tasks	☐	☐
2. Complete tasks	☐	☐
3. Concentration	☐	☐

OTHER PROBLEMS		
1. Paranoid	☐	☐
2. Fearful	☐	☐
3. Loss of confidence	☐	☐
4. Irritable	☐	☐
5. Mood swings	☐	☐
6. Inappropriate laughing or crying	☐	☐
7. Impolite, embarrassing comments to others	☐	☐
8. Physical / verbal aggression	☐	☐
9. Confusion – disoriented	☐	☐
10. Hallucinations (things or people that aren't there	☐	☐
11. Repetitive actions (sorting, wandering, muttering)	☐	☐

FUNCTIONAL STATUS:

Please check the appropriate box:

Activities of Daily Living	No Assistance	With Assistance	Total Care
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Toileting	☐	☐	☐
Transferring / Walking	☐	☐	☐
Continence	☐	☐	☐
Feeding	☐	☐	☐

COMMENTS

Instrumental Activities of Daily Living			
Using Telephone	☐	☐	☐
Grocery Shopping	☐	☐	☐
Preparing Meals	☐	☐	☐
Doing Housework	☐	☐	☐
Doing Laundry	☐	☐	☐
Taking Medications	☐	☐	☐
Managing Finances	☐	☐	☐
Driving	☐	☐	☐

COMMENTS

Name: _____ DOB: _____

INDICATE WHICH APPLY TO YOU

GENERAL	Yes	No
1. Frequent infections	☐	☐
2. Weight change	☐	☐
3. Appetite / thirst change	☐	☐
4. Excessive fatigue / nervousness	☐	☐
5. Difficulty sleeping	☐	☐
6. Enlarged / tender lymph nodes or glands	☐	☐
7. Other _____		

EYES	Yes	No
1. Do you wear glasses / contacts	☐	☐
2. Vision changes	☐	☐
3. Red/itchy, water eyes	☐	☐
4. Eye pain	☐	☐
5. Glaucoma	☐	☐
6. Dry eyes	☐	☐
7. Macular Degeneration	☐	☐
8. Other _____		

EARS	Yes	No
1. Infections	☐	☐
2. Hearing loss	☐	☐
3. Earaches	☐	☐
4. Ear drainage	☐	☐
5. Buzzing / ringing	☐	☐
6. Feel “stopped up”	☐	☐
7. Other _____		

NOSE AND THROAT	Yes	No
1. Nasal stuffiness / drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Mouth sores / ulcers	☐	☐
5. Hoarseness	☐	☐
6. Changes in taste	☐	☐
7. Teeth / gum problems	☐	☐
8. Snoring	☐	☐
9. Sleep apnea *(stop breathing while sleeping)*	☐	☐
10. Other _____		

PULMONARY	Yes	No
1. Shortness of breath / difficulty breathing	☐	☐
2. Cough-dry / productive	☐	☐
3. Asthma / wheezing	☐	☐
4. Night sweats	☐	☐
5. Fever / chills	☐	☐
6. Other _____		

CARDIOVASCULAR	Yes	No
1. Heart attack / failure / angina	☐	☐
2. Chest pain / tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Murmur	☐	☐
8. Other _____		

GASTROINTESTINAL	Yes	No
1. Heartburn / indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains / ulcers	☐	☐
4. Nausea / vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools / diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Rectal bleeding	☐	☐
10. Black / bloody stools	☐	☐
11. Changes in bowel habits	☐	☐
12. Frequent laxatives	☐	☐
13. Liver problems / jaundice hepatitis	☐	☐
14. Gallstones	☐	☐
15. Other _____		

BREAST	Yes	No
1. Lumps	☐	☐
2. Pain	☐	☐
3. Discharge	☐	☐
4. Other_____		

MALES ONLY	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain / lumps / swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Venereal disease	☐	☐
7. Genital concerns	☐	☐
8. Other_____		

FEMALES ONLY	Yes	No
1. Vaginal discharge / odor	☐	☐
2. Vaginal dryness	☐	☐
3. Painful intercourse	☐	☐
4. Menopause / symptoms	☐	☐
5. Sexual difficulties	☐	☐
6. Venereal disease	☐	☐
7. Genital concerns	☐	☐
8. Other_____		

MUSCULOSKELETAL	Yes	No
1. Joint pain / tenderness	☐	☐
2. Joint swelling / warmth	☐	☐
3. Joint stillness	☐	☐
4. Joint deformity	☐	☐
5. Muscle pain	☐	☐
6. Back / neck pain	☐	☐
7. Weakness	☐	☐
8. Prone to falls	☐	☐
9. Other _____		

SKIN	Yes	No
1. Rashes	☐	☐
2. Dry / itchy skin	☐	☐
3. Bruising	☐	☐
4. Sweats	☐	☐
5. Mole / lesion changes	☐	☐
6. Skin color changes	☐	☐
7. Skin growths	☐	☐
8. Hair / nail problems	☐	☐
9. Other _____		

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

PSYCHIATRIC	Yes	No
I. Confusion	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐
5. Overly emotional/ mood swings	☐	☐
6. Hallucinations	☐	☐
7. Phobias	☐	☐
8. Other _____		

URINARY	Yes	No
1. Pain / burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence *(wetting)*	☐	☐
5. Bloody urine	☐	☐
6. Other _____		