

**WELCOME** to the Stead Family Memory Center at Banner Alzheimer's Institute (BAI)! As a Center of Excellence focused on the diagnosis, treatment, and study of Alzheimer's disease (and related disorders), we offer a comprehensive approach by an interdisciplinary team of specialists. We understand that memory and thinking problems affect both the person and the family, therefore our services target both.

**STEP 1 – COMPLETE THE “NEW PATIENT” PACKET:** Please follow the directions provided in the packet. After you've completed the packet, please print the packet and sign the “Authorization to Use or Disclose Protected Health Information” form. Then either fax the packet to our secure line (602) 839-6906, email it to us at [BAInfo@bannerhealth.com](mailto:BAInfo@bannerhealth.com), or mail it directly to us at the following address:

Banner Alzheimer's Institute  
Stead Family Memory Center  
901 East Willetta Street  
Phoenix, AZ 85006

**STEP 2 – SCHEDULING THE FIRST VISIT.** We will call to schedule your visit once we have received the completed packet. Please plan to have a family member or close friend accompany you to this visit. Please make sure to bring a current medication list and glasses or hearing aids with you to all visits.

**STEP 3 – FOLLOW PRESCRIBED TREATMENT PLAN:** After a diagnosis is established, the physician will formulate a treatment plan. Ongoing medical needs will be addressed along with the need for education, support and community resources. Information will also be provided regarding possible participation in clinical research.

**STEP 4 – ATTEND EDUCATIONAL CLASSES:** You are urged to attend two free classes prior to or following the first clinic appointment: COMPASS, a 90-minute class to learn the essentials of dementia and caregiving; and Planning Ahead, a 2-hour class to understand the important medical, legal and financial decisions that must be addressed. These can be attended in person at Banner Alzheimer's Institute or viewed online. For these online classes as well as a full list of education and support programs, visit our website at [www.banneralz.org](http://www.banneralz.org) and click on “Education and Events.”

We are committed to setting a new standard of care for patients and families. We want to provide an exceptional experience – one that leaves everyone with hope and help! We look forward to seeing you and your family in the very near future!

Sincerely,

*William J Burke, MD*

Dr. William J. Burke, M.D.  
Director, Stead Family Memory Center

Enclosures: New Patient Packet  
Authorization to Use or Disclose Protected Health Information

## NEW PATIENT PACKET

PATIENT INFORMATION			
Name (First, Middle, Last)		Age	Date of Birth (Required)
Address		City	State Zip Code
Home Phone	Cell Phone		SSN#
Email Address			
Emergency Contact			
Name:		Relationship:	Phone Number(s):
Relationship Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partner			
Primary Language(s): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
First language learned: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			
Ethnic Background: <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other:			

PERSON COMPLETING PACKET (IF DIFFERENT THAN ABOVE)			
Name (First, Middle, Last)		Relationship to patient	
Address		City	State Zip Code
Home Phone		Cell Phone	
Years you have known the patient		Your Age	Today's Date:
How often do you see the patient?			
<input type="checkbox"/> Every day <input type="checkbox"/> 2 – 3 days per week <input type="checkbox"/> 4 – 6 days per week <input type="checkbox"/> Once every 2 weeks <input type="checkbox"/> Once per month <input type="checkbox"/> Less than once per month			
How many hours a week do you spend with him/her?			

ADDITIONAL CONTACT INFORMATION	
Email address:	Can we send you e-mail messages? <input type="checkbox"/> Yes <input type="checkbox"/> No
*All email messages will come encrypted to protect confidential patient information	
Can we contact you to set up the new patient appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Your preferred method of contact? <input type="checkbox"/> Home <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email	
If no, who should be the primary contact person:	
Name (First, Middle, Last)	Relationship to patient
Which is the best method to contact the above-named person?	
<input type="checkbox"/> Home: <input type="checkbox"/> Cell: <input type="checkbox"/> Email:	

## NEW PATIENT PACKET

Can we leave a message with the primary contact?			
<input type="checkbox"/> YES, best method to leave a message:	<input type="checkbox"/> Home	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Email
<input type="checkbox"/> NO, don't leave a message please			

### POWER OF ATTORNEY

Does the patient have a durable <u>Health Care</u> Power of Attorney? If yes, who is so named?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have a durable <u>Mental Health</u> Power of Attorney? If yes, who is so named?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*IF YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, **PLEASE BRING A COPY OF THE SUPPORTING DOCUMENTS TO THE INITIAL VISIT.***

### GENERAL INFORMATION

Has the patient had a consultation or work up for current symptoms? If yes, please provide his/her contact information below:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician Name:	Phone Number		
How long has the patient been seeing this physician?	Fax Number		
Does the patient have a primary care physician? If yes, please provide his/her contact information below:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician Name:	Phone Number		
How long has the patient been seeing this physician?	Fax Number		
How did you hear about the MEMORY CENTER? <input type="checkbox"/> Friend <input type="checkbox"/> Agency <input type="checkbox"/> Physician <input type="checkbox"/> Other:			

### PHARMACY INFORMATION

Local Pharmacy Name	Local Pharmacy Phone
Local Pharmacy Address	
Mail Order Pharmacy Name	ID# (required)
Mail Order Pharmacy Address	

## NEW PATIENT PACKET

### HEALTH INSURANCE INFORMATION

**PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY.  
MISSING INFORMATION WILL DELAY PROCESSING.**

#### PRIMARY INSURANCE

Insurance Name	Member ID#
Insurance Claims Address	Group #
Policy Holder Name	
Relationship to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner (Member ID#: _____) <input type="checkbox"/> Dependent	

#### PRIMARY INSURANCE PHONE (EACH CAN BE FOUND ON INSURANCE CARD)

Member's insurance toll free phone number:
Insurance notification/provider's toll-free phone:

#### SECONDARY INSURANCE

Insurance Name	Member ID#
Insurance Claims Address	Group #
Policy Holder Name	
Relationship to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner (Member ID#: _____) <input type="checkbox"/> Dependent	

#### SECONDARY INSURANCE PHONE (EACH CAN BE FOUND ON INSURANCE CARD)

Member's insurance toll free phone number:
Insurance notification/provider's toll-free phone:

## NEW PATIENT PACKET

CURRENT PROBLEM	
What is the main reason for the person's visit to the clinic?	
What were the person's initial symptoms and when did they develop?	
When were these initial symptoms first observed?	
Did the symptoms occur suddenly or develop gradually over time? <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually	
Have the symptoms changed over time? <input type="checkbox"/> Stable <input type="checkbox"/> Stable, then sudden decline <input type="checkbox"/> Steadily Worsened <input type="checkbox"/> Fluctuating <input type="checkbox"/> Improved	
Has the patient ever suffered symptoms of delirium? (periods of extreme confusion or disorientation due to illness, medication side-effects or being in the hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
If yes, please state the approximate year(s) and describe the event(s).	

**PEOPLE MAY EXPERIENCE CHANGES IN MANY ABILITIES. HELP US UNDERSTAND THE PERSON'S CURRENT ABILITIES BY MARKING THE BOXES BELOW.**

MEMORY & THINKING – DOES SHE/HE HAVE PROBLEMS WITH:				
	Never	Sometimes	Often	Always
Recalling recent events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recalling details of conversations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeating questions or stories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Misplacing or losing items	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetting dates, schedules, or appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognizing familiar places, people, or objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recalling events from the distant past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning a new route to an unfamiliar place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming lost or confused in familiar places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finding words or expressing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**NEW PATIENT PACKET**

**MEMORY & THINKING (CONTINUED)– DOES SHE/HE HAVE PROBLEMS WITH:**

	Never	Sometimes	Often	Always
Understanding others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making judgments or solving problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying out multi-step activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multitasking (performing two tasks at one time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Focusing, concentrating, or being easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DAILY TASKS – DOES SHE/HE HAVE PROBLEMS WITH THESE ACTIVITIES (SPECIFICALLY RELATED TO CHANGES IN MEMORY & THINKING):**

	N/A*	Never	Sometimes	Often	Always
<b>Medications</b>					
Preparing/organizing medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recalling use and/or dosage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetting to take medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making other medication errors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Finances</b>					
Preparing/completing taxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizing/preparing bill payment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bill payment (paying late or twice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing checkbook/online account	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculating a tip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Household Tasks</b>					
Shopping or making purchases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking, grilling, or preparing food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household chores or simple repairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arranging transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using technology (tools, microwave, thermostat, computer, smartphone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*Please check the N/A box, if the person has never performed the task(s) or you do not know.

## NEW PATIENT PACKET

### PERSONAL CARE AND GROOMING – HOW DOES SHE/HE COMPLETE THESE ACTIVITIES:

	Completely Independent	Verbal reminders	Physical assistance	Completely Dependent
Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Combing/styling hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushing teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applying or removing makeup, if applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing or showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing or undressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating using utensils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing and swallowing correctly/safely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### JUDGMENT AND SAFETY - DOES SHE/HE HAVE PROBLEMS WITH:

<input type="checkbox"/> Leaving the stove on or microwave fires	<input type="checkbox"/> Wandering off or getting lost
<input type="checkbox"/> Leaving the water on	<input type="checkbox"/> Forgetting to eat
<input type="checkbox"/> Having trouble regulating the thermostat	<input type="checkbox"/> Living alone or being left alone
<input type="checkbox"/> Having access to weapons or power tools	<input type="checkbox"/> Being susceptible to solicitors

Does the person currently drive a motor vehicle?  Yes  No

If he/she drives, are you concerned about his/her safety?  Yes  No

If you answered "Yes" to the question above, please check any of the following areas of concern.

<input type="checkbox"/> Drives too fast	<input type="checkbox"/> Gets angry or flustered	<input type="checkbox"/> Straddles lanes
<input type="checkbox"/> Drives too slow	<input type="checkbox"/> Turns in front of other cars	<input type="checkbox"/> Runs overs curbs
<input type="checkbox"/> Gets lost	<input type="checkbox"/> Hits/scrapes objects	<input type="checkbox"/> Doesn't pay attention
<input type="checkbox"/> Recent accidents/citations	<input type="checkbox"/> Trouble parking	<input type="checkbox"/> Other:

**NEW PATIENT PACKET**

**MOOD AND BEHAVIOR:** Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. Check the box only if the symptom(s) has been present in the last month.

	Not Applicable	Mild	Moderate	Severe
Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have hallucinations, such as false visions or voices? Does he/she seem to hear or see things that are not present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient resistive to help from others at times or hard to handle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient seem sad, or say that he/she is depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax or feeling excessively tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient appear to feel too good or act excessively happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient seem less interested in his/her usual activities, or in the activities or plans of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them or saying things that may hurt people's feelings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string or doing other things repeatedly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient awaken you during the night, rise too early in the morning or take excessive naps during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient lost or gained weight, or had a change in the type of food he/she likes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## NEW PATIENT PACKET

### PERSONALITY AND BEHAVIOR:

Please check any of the following words that describe her/his life-long PERSONALITY:

- |  |  |  |                                      |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Even tempered     | <input type="checkbox"/> Quick tempered  | <input type="checkbox"/> Optimistic          | <input type="checkbox"/> Pessimistic |
| <input type="checkbox"/> Socially outgoing | <input type="checkbox"/> "Homebody"      | <input type="checkbox"/> Worrier             | <input type="checkbox"/> Stubborn    |
| <input type="checkbox"/> Low self-esteem   | <input type="checkbox"/> Assertive       | <input type="checkbox"/> Manipulative        | <input type="checkbox"/> Complainer  |
| <input type="checkbox"/> Hypochondriac     | <input type="checkbox"/> Generous/caring | <input type="checkbox"/> Good sense of humor |                                      |

Has the patient experienced any CHANGES in personality or behavior, such as:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Increased impulsivity | <input type="checkbox"/> Reduced frustration tolerance   | <input type="checkbox"/> Increased irritability |
| <input type="checkbox"/> Agitation             | <input type="checkbox"/> Difficulty getting started      | <input type="checkbox"/> Reduced motivation     |
| <input type="checkbox"/> Loss of empathy       | <input type="checkbox"/> Socially inappropriate behavior | <input type="checkbox"/> Restlessness           |
| <input type="checkbox"/> Risky behaviors       | <input type="checkbox"/> Social withdrawal               | <input type="checkbox"/> Other, describe:       |

### SLEEP - DOES SHE/HE HAVE PROBLEMS WITH:

<input type="checkbox"/> "acting out dreams" while sleeping (punching or flailing arms in the air, shouting or screaming)	<input type="checkbox"/> legs repeatedly jerking or twitching <u>during</u> sleep (not just when falling asleep)
<input type="checkbox"/> a restless, nervous, tingly, or creepy-crawly feeling in legs that disrupts falling/staying asleep	<input type="checkbox"/> walking around the bedroom or house while asleep
<input type="checkbox"/> snorting or choking him/herself awake	<input type="checkbox"/> seem to stop breathing during sleep
<input type="checkbox"/> increased need for sleep	<input type="checkbox"/> excessive daytime sleepiness/drowsiness
<input type="checkbox"/> difficulty falling asleep	<input type="checkbox"/> difficulty staying asleep

### CAREGIVER CONCERNS-IF YOU ARE A CAREGIVER, WHICH OF THE AREAS BELOW CONCERN YOU?

Financial/Legal	<input type="checkbox"/> YES	If yes, please describe
Physical Health	<input type="checkbox"/> YES	If yes, please describe
Mental Health	<input type="checkbox"/> YES	If yes, please describe
Managing Problem Behaviors	<input type="checkbox"/> YES	If yes, please describe
Decisions about alternative care options	<input type="checkbox"/> YES	If yes, please describe
Other	<input type="checkbox"/> YES	If yes, please describe

## NEW PATIENT PACKET

### MEDICAL HISTORY

Check below if the patient has experienced any of the following?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Head trauma or brain injury | <input type="checkbox"/> Loss of consciousness            | <input type="checkbox"/> Stroke or TIA (mini-stroke) |
| <input type="checkbox"/> Difficulty walking, falls   | <input type="checkbox"/> Exposure to toxins               | <input type="checkbox"/> Brain infections            |
| <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Other neurological condition(s): |  |

If you checked any of the above, description(s) and date(s):

Please list any birth injuries or illnesses:

Please list any childhood/adolescent injuries or illnesses:

Any history of learning disability or ADD/ADHD?  Yes  No

Did the patient ever repeat a grade or receive special education?  Yes  No

If yes to either of these questions, please describe:

Check below if the patient has the following conditions and/or is treated for the following conditions?

- |  |  |   |                                   |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Atrial fibrillation         | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sleep apnea         | <input type="checkbox"/> Other cardiac abnormalities |   |                                   |

Has the patient had a brain scan?  Yes  No

If yes, location:

Date:

Has the patient had a neuropsychological evaluation?  Yes  No  
(usually over 2 hours of testing of thinking skills)

If yes, by whom:

Date:

### MEDICATION HISTORY

#### ALLERGIES

Please list allergies to medications:

Please list allergies to foods:

Please list other allergies:

## NEW PATIENT PACKET

**PLEASE LIST ALL MEDICATIONS TAKEN WITHIN THE LAST MONTH:**

PRESCRIPTION MEDICATIONS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED
NONPRESCRIPTION MEDICATIONS, SUPPLEMENTS, VITAMINS					
DRUG NAME	DOSE	TIMES PER DAY	DATE STARTED	DATE STOPPED	MEDICAL CONDITION BEING TREATED

**NEW PATIENT PACKET**

**PLEASE LIST PAST AND CURRENT MEDICAL, NEUROLOGICAL AND PSYCHIATRIC PROBLEMS**

PROBLEM	DIAGNOSIS DATE	ACTIVE	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

SURGICAL HISTORY		
TYPE OF SURGERY	HOSPITAL	DATE

HOSPITALIZATIONS		
REASONS FOR HOSPITALIZATION	HOSPITAL	DATE

## NEW PATIENT PACKET

### SYSTEM REVIEW

**PLEASE REVIEW THIS AND CHECK "YES" FOR ANY SYMPTOMS THE PATIENT IS EXPERIENCING CURRENTLY**

YES	CONSTITUTIONAL
<input type="checkbox"/>	Chills
<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Fever
<input type="checkbox"/>	Malaise (general discomfort)
<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	Weight Gain
<input type="checkbox"/>	Weight Loss

YES	HEENT (HEAD, EYES, EARS, NOSE, THROAT)
<input type="checkbox"/>	Ear Drainage
<input type="checkbox"/>	Ear Pain
<input type="checkbox"/>	Eye Discharge
<input type="checkbox"/>	Eye Pain
<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	Nasal Drainage
<input type="checkbox"/>	Sinus Throat
<input type="checkbox"/>	Visual Changes

YES	RESPIRATORY
<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	Cough
<input type="checkbox"/>	Known TB Exposure
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Asthma

YES	CARDIOVASCULAR
<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	Leg pain with walking
<input type="checkbox"/>	Edema
<input type="checkbox"/>	Palpitations (abnormal heart beats)

YES	GASTRO-INTESTINAL
<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	Blood in Stools
<input type="checkbox"/>	Change in Stools
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Vomiting

YES	GENITOURINARY
<input type="checkbox"/>	Dribbling
<input type="checkbox"/>	Burning with urination
<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	Excessive urination
<input type="checkbox"/>	Slow Stream
<input type="checkbox"/>	Urinary Frequency
<input type="checkbox"/>	Urinary Incontinence
<input type="checkbox"/>	Urinary Retention

YES	REPRODUCTIVE
<input type="checkbox"/>	Erectile Dysfunction (men)
<input type="checkbox"/>	Penile/Vaginal Discharge
<input type="checkbox"/>	Sexual Dysfunction
<input type="checkbox"/>	Abnormal Pap Smear (women)
<input type="checkbox"/>	Breast discharge or lump (women)
<input type="checkbox"/>	Painful menstrual periods (women)
<input type="checkbox"/>	Pain with intercourse
<input type="checkbox"/>	Hot flashes (women)
<input type="checkbox"/>	Irregular menstrual periods (women)

YES	METABOLIC/ENDO
<input type="checkbox"/>	Brittle Hair
<input type="checkbox"/>	Brittle Nails
<input type="checkbox"/>	Cold Intolerance
<input type="checkbox"/>	Hair changes
<input type="checkbox"/>	Heat Intolerance
<input type="checkbox"/>	Excessive Hair Growth
<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	Excessive eating

YES	NEUROLOGICAL
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Extremity Numbness
<input type="checkbox"/>	Extremity Weakness
<input type="checkbox"/>	Walking or Balance Problems
<input type="checkbox"/>	Headache
<input type="checkbox"/>	Memory Loss
<input type="checkbox"/>	Seizures/Convulsions
<input type="checkbox"/>	Tremors
<input type="checkbox"/>	Sudden Loss of Consciousness

YES	PSYCHIATRIC
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Insomnia

YES	SKIN
<input type="checkbox"/>	Contact Allergy
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Itching
<input type="checkbox"/>	Mole Changes
<input type="checkbox"/>	Rash
<input type="checkbox"/>	Skin Lesion

YES	MUSCULO-SKELETAL
<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	Joint Swelling
<input type="checkbox"/>	Muscle Weakness
<input type="checkbox"/>	Neck Pain

YES	HEMOTOLOGIC/ LYMPHATIC
<input type="checkbox"/>	Easy Bleeding
<input type="checkbox"/>	Easy Bruising
<input type="checkbox"/>	Swollen glands

YES	IMMUNOLOGIC
<input type="checkbox"/>	Environmental Allergy
<input type="checkbox"/>	Food Allergy
<input type="checkbox"/>	Seasonal Allergy

PHYSICIAN NOTES

## NEW PATIENT PACKET

SOCIAL HISTORY	
Formal education completed:	
<input type="checkbox"/> Less than high school; highest grade completed: <input type="checkbox"/> GED <input type="checkbox"/> High School <input type="checkbox"/> Some college <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctoral Degree	
Retired: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, year retired:	
<u>If working</u> , current occupation:	<u>If no longer working</u> , prior occupation:
Years in Current Occupation: Currently working: <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	Years in Occupation: Worked: <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time
Hobbies/Interests	
Does/did memory and thinking problems affect(ed) working or hobbies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of living children:	Number of daughters:      Number of sons:
Current living situation:	
<input type="checkbox"/> Alone in home/apt <input type="checkbox"/> With spouse/significant other <input type="checkbox"/> With other family or friends <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing home <input type="checkbox"/> Other:	

SUBSTANCE USE HISTORY	
TOBACCO USE	
Does the patient currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: # of packs per day:	# of years smoked:
Did the patient ever smoke in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, year quit:
If patient ever smoked, # of packs per day:	# of years smoked:

ALCOHOL USE	
<u>Current use</u> : How many drinks per week?	
<u>Past use</u> : How many drinks per week?	
Any history of excess use (now or in the past)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SUBSTANCE USE		
Has the patient used medical marijuana, recreational drugs, and/or misused prescription medications recently and/or in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes:	Type:	Duration:

## NEW PATIENT PACKET

### FAMILY HISTORY

#### DOES THE PATIENT HAVE A BLOOD RELATIVE WITH SYMPTOMS OF OR DIAGNOSIS OF:

Dementia/Senility/Alzheimer's? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, relationship and age of onset of memory problems:		
Parkinson's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, relationship:	
Strokes? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, relationship:	
Psychiatric/Mental Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, relationship:	
Intellectual Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, relationship:	
How many brothers?:	How many sisters?:	
Does the patient have living siblings without Dementia? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list diseases/illnesses in your family:		
<u>Mother:</u>		
<u>Father:</u>		
<u>Siblings:</u>		
<ul style="list-style-type: none"> <li>• Brothers:</li> <li>• Sisters:</li> </ul>		
<u>Children:</u>		
<u>Grandparents:</u>		
<ul style="list-style-type: none"> <li>• Mother's side:</li> <li>• Father's side:</li> </ul>		



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)**

<b>Organization Who Is Releasing Information</b>		<b>To Whom Information Will Be Provided</b>	
Facility:		Entity/Individual: Banner Alzheimer's Institute	
Address:		Address: 901 E Willetta Street	
City, State	Zip Code	City, State Phoenix, AZ	Zip Code 85006
Fax:	Phone:	Fax: 602-839-6906	Phone: 602-839-6900

<b>Patient Information:</b>	Patient Name: _____	Date of Birth: _____
	Address: _____	Phone Number: _____
<b>Dates Requested:</b>	FROM: _____	TO: _____

\*There May be a FEE Associated with your Request for Records

<b>Records Being Requested:</b>	<b>Health Center/Clinic Records</b> <input type="checkbox"/> Office Visit/Progress Note <input type="checkbox"/> Immunization Record <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Laboratory Report <input type="checkbox"/> Medication List <input type="checkbox"/> EKG Report <input type="checkbox"/> Imaging/X-ray Report <input type="checkbox"/> Imaging/X-ray CD/Film <input type="checkbox"/> Consultation <input type="checkbox"/> Behavioral/Psychiatric Office visit <input type="checkbox"/> Official Medical Record <input type="checkbox"/> Other _____	<b>Hospital Records</b> (Only From Non-Banner Hospital) <input type="checkbox"/> <b>All Pertinent Records</b> (includes those listed below) <input type="checkbox"/> Allergies <input type="checkbox"/> Consultation <input type="checkbox"/> Discharge Summary <input type="checkbox"/> ER Report <input type="checkbox"/> EKG Report <input type="checkbox"/> History & Physical <input type="checkbox"/> Laboratory <input type="checkbox"/> Medication List <input type="checkbox"/> Operative Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Problem List <input type="checkbox"/> X-Ray Report <input type="checkbox"/> Other _____
	<b>Other Records:</b> <input type="checkbox"/> Billing Record <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Photos Further explanation of request: _____	
<b>Delivery of Records:</b>	<b>Paper Requests</b> <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up <input type="checkbox"/> Courier <input checked="" type="checkbox"/> Fax <b>Electronic Requests</b> <input type="checkbox"/> E-mail <input type="checkbox"/> CD <input type="checkbox"/> I <u>Do Not</u> want my electronic record Encrypted <input type="checkbox"/> I <u>Do</u> want my electronic record Encrypted <div style="border: 1px solid black; padding: 5px; text-align: center;">           Email Address for record delivery            _____            _____            _____         </div> <p style="text-align: center;">(Complete ONLY if requesting records via Email)          *Unencrypted data sent by email can be intercepted by Unauthorized Parties*</p>	
<b>Purpose:</b>	<input type="checkbox"/> Self <input checked="" type="checkbox"/> Continuing Care <input type="checkbox"/> Other (please specify): _____	



\*1200\* HIMS/ROI



## NEW PATIENT PACKET



### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Health Center/Clinic)

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing: my signature authorizes release of any such information.

I may refuse to sign this authorization form. I understand that Banner will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Banner Health's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

I understand that I have a right to receive a copy of this authorization.

This Authorization pertains to the dates specified on this Authorization. Unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand that if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Banner Health, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

For Healthcare Use Only		
Employee printed name who completed/reviewed form with patient:		
Verbal Release or Viewed EMR (document information/person authorized):		
Date Received:	Date Completed:	Processing Initials:
POA Verified:	ID/License Verified:	
Comments for CROI:		

Records picked up by: \_\_\_\_\_ Date \_\_\_\_\_