

WELCOME to the Toole 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 (520) 694-0235, email it to us at BAITucsonMemoryClinic@bannerhealth.com, or mail it directly to us at the following address:

Banner Alzheimer's Institute
Toole Family Memory Center
2626 E. River Road
Tucson, AZ 85718

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 participate in our 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 are recommended. They are offered in person at Banner Alzheimer's Institute or viewed online. We also offer a monthly e-newsletter, the BAI Beacon. To view online education, sign up for the newsletter and learn about other education and support programs, please visit our website at www.banneralz.org.

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,



Dr. Allan A. Anderson
Director, Toole Family Memory Center

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

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
First language learned: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			<input type="checkbox"/> Male <input type="checkbox"/> Female
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:			

Can we leave a message with the primary contact?

- YES, best method to leave a message:
 Home
 Cell Phone
 Email
 NO, don't leave a message please

POWER OF ATTORNEY

Does the patient have a durable Health Care Power of Attorney? Yes No
 If yes, who is so named?

Does the patient have a durable Mental Health Power of Attorney? Yes No
 If yes, who is so named?

*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? Yes No
 If yes, please provide his/her contact information below:

Physician Name:	Phone Number
How long has the patient been seeing this physician?	Fax Number

Does the patient have a primary care physician? Yes No
 If yes, please provide his/her contact information below:

Physician Name:	Phone Number
How long has the patient been seeing this physician?	Fax Number

How did you hear about the MEMORY CENTER?
 Friend Agency Physician Other:

PHARMACY INFORMATION

Local Pharmacy Name	Local Pharmacy Phone
Local Pharmacy Address	

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

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:

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"/>

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
Medications					
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"/>
Finances					
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"/>
Household Tasks					
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.

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												
<p>Does the person currently drive a motor vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If he/she drives, are you concerned about his/her safety? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered "Yes" to the question above, please check any of the following areas of concern.</p> <table> <tbody> <tr> <td><input type="checkbox"/> Drives too fast</td> <td><input type="checkbox"/> Gets angry or flustered</td> <td><input type="checkbox"/> Straddles lanes</td> </tr> <tr> <td><input type="checkbox"/> Drives too slow</td> <td><input type="checkbox"/> Turns in front of other cars</td> <td><input type="checkbox"/> Runs overs curbs</td> </tr> <tr> <td><input type="checkbox"/> Gets lost</td> <td><input type="checkbox"/> Hits/scrapes objects</td> <td><input type="checkbox"/> Doesn't pay attention</td> </tr> <tr> <td><input type="checkbox"/> Recent accidents/citations</td> <td><input type="checkbox"/> Trouble parking</td> <td><input type="checkbox"/> Other:</td> </tr> </tbody> </table>		<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:
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<input type="checkbox"/> Recent accidents/citations	<input type="checkbox"/> Trouble parking	<input type="checkbox"/> Other:											

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"/>

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

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:

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

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

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:	Years in Occupation:
Currently working: <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time	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:

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"> • Brothers: • Sisters: 		
<u>Children:</u>		
<u>Grandparents:</u>		
<ul style="list-style-type: none"> • Mother's side: • Father's side: 		



**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.

Yes No **DO THE REQUESTED RECORDS INCLUDE DRUG/ALCOHOL TREATMENT**

RECEIVED: If yes, I release my drug and alcohol information for the following purpose:

The information to be released should include my entire record requested except for the following:

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 _____