UNIVERSITY MEDICAL GROUP

Patient Privacy Questionnaire and Notification

Patient Name:_____ Date of Birth:_____

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at*: _____Home #_____

_____Cell #_____

_____Work #_____

_____Other #_____

_____May ONLY leave information with me. (If you check here, no other choice should be marked).

_____May leave appointment reminders on my answering machine/voicemail.

_____May leave lab results on my answering machine/voicemail.

_____May leave general questions/information on my answering machine/voicemail.

_____May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:

Name:_____Relationship:_____

Name:_____Relationship:_____

_____May leave appointment reminders with the above listed person

_____May leave lab results with the above listed person

_____May leave general questions/information with the above listed person

_____May discuss billing information with the above listed person

_____I prefer that all healthcare messages be given to the above listed person

*If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

Signature of Patient_____ Date_____

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

The Pat Summitt Clinic
1932 Alcoa Hwy
Medical Office Building C, Suite 150
Knoxville, TN 37920
865-305-2273 (Phone) | 865-305-7311 (Fax)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____ **Date of birth:** _____

SSN: _____ Address: _____

_____

I hereby authorize the release of medical records to The Pat Summitt Clinic

Records to be released from: _____

For the following purpose: Medical Treatment

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, Condition or dates of treatment: _____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

_____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance and thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient **Date**

Notice of Research:
Use of Your Personal and Health Information for Research at The Pat Summitt Clinic

NAME: _____ DATE OF BIRTH: _____ MR#: _____

As part of your routine care at the Pat Summitt Clinic at the University of Tennessee Medical Center (UTMC), your personal and health information is stored in a secure database.

Researchers at the Pat Summitt Clinic want to learn more about diseases that affect thinking abilities, like Alzheimer's disease, so that they can improve the care of patients in the future. We are asking you to authorize the use of your personal and health information stored in the Pat Summitt clinical database for this research. Participation in this research is completely voluntary. No matter what you decide, your clinical care will not be affected.

If you agree to participate, UTMC researchers may use your personal and health information to conduct research studies in the future without your additional consent. UTMC researchers will conduct research using your information, including data that could be used to identify you (i.e., name, date of birth, medical record number, address, etc.), with the approval of the Institutional Review Board. (An Institutional Review Board is a committee that reviews ethical issues, according to federal, state, and local regulations on research with human participants.) Researchers not associated with UTMC may conduct research with your information after it has been stripped of data that could identify you (i.e., name, date of birth, medical record number, address, etc.).

If you agree to participate, you will not receive payment for your participation and you will not receive any results from research conducted with your information. You will not be informed of the details of studies that use your information. The research conducted with your information may lead to new medical knowledge, tests, treatments, or products. These products could have some financial value or be used for commercial profit. There are no plans to provide financial payment to you or your relatives if this occurs.

By participating there is an unlikely risk that someone could get access to your information and that your identity could become known.

If you choose to participate, you can stop participating at any time by calling Dr. Roberto Fernandez at 865-305-7242 and withdrawing your authorization to use your information in research. If you withdraw your permission to use your information in research, your information will not be used in studies conducted after that time. However, we cannot withdraw information that has already been included in previous or ongoing studies.

If you have questions regarding the use of your personal or health information for research at the Pat Summitt Clinic, you can contact Dr. Roberto Fernandez at 865-305-7242. If you have questions about your rights as a research subject, you can contact the UT Graduate School of Medicine Institutional Review Board office at 865-305-9781.

Please Check One of the Following:

☐ I **accept** and authorize the use of my personal and health information for research purposes as described above.

☐ I **decline**, and do not authorize the use of my personal and health information for research purposes as described above.

The undersigned certifies that he/she has read the foregoing or has had the foregoing read to him/her, and that he/she understands and fully accepts its terms.

Signature of the Patient: _____ Date of Signing: ____/____/_____

Or

Signature of the Patient's

Legal Representative: _____ Date of Signing: ____/____/_____

Alzheimer's and Dementia Care Program
PRE-VISIT PATIENT QUESTIONNAIRE

We highly recommend completing the following form with a caregiver or family member

Thank you for investing the time to complete this form before your visit . The information you provide here will allow your care manager to perform the most complete evaluation possible when you arrive for your appointment. Your time and effort is much appreciated.

1. Date form completed: _____ / ____ / _____
Month Day Year

2. Name of patient: _____ _____
Last First

3. Mailing Address: _____ _____
Street Apartment

_____ _____ _____
City State Zip

4. Phone: (_____) _____ - _____

5. Date of birth: _____ / ____ / _____
Month Day Year

6. Sex: ☐ Male ☐ Female

7. What is the patient's primary language spoken? _____

Secondary? _____

8. What hand do you write with?

☐ Left ☐ Right ☐ Both

9. Who filled out this form?

☐ Patient (Skip to question 9) ☐ Other (please provide information below)

Name: _____ Phone number: (_____) _____ - _____

Address: _____ _____
Street Apartment

_____ _____ _____
City State Zip

Email address: _____

If other person completed this form, what is the relationship of the person to the patient?
☐ Spouse ☐ Child ☐ Friend ☐ Other (specify): _____

What is the best time during business hours to contact you? _____

10. Who has been your primary care doctor? Provide information below.

Name: _____

Address: _____ _____
Street Suite

_____ _____ _____
City State Zip

Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____

11. OTHER MEDICAL SPECIALIST(S)
List the doctors you see besides your primary care provider or family doctor.

Physician's Name:_____ Speciality_____

Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____

Physician's Name:_____ Speciality_____

Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____

Physician's Name:_____ Speciality_____

Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____

Physician's Name:_____ Speciality_____

Phone number: (_____) _____ - _____ Fax number: (_____) _____ - _____

12. ALLERGIES

Do you have any drug or food allergies? ☐ Yes ☐ No

If yes, please list name of drug and indicate reaction.

Name of Drug/Food	Describe Reaction

13. MEDICATIONS

List all medications, including all prescription, non-prescription, and natural products

Current Medication	What strength?	Are you Currently Taking?	How do you use it? (How many? How many times a day?)
Example: Tylenol	500mg		1 pill 3x a day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

14. PAST MEDICAL HISTORY

A. Which medical conditions do you have now or have had in the past?
(Please check all that apply)

EYE & EAR

- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss/hearing aid
- ☐ Other (specify): _____

HEART

- ☐ Heart attack, year: _____
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Aortic stenosis
- ☐ Heart valve problem
- ☐ Angina
- ☐ High cholesterol
- ☐ Pacemaker
- ☐ Atrial fibrillation
- ☐ Irregular heartbeats (arrhythmias)
- ☐ Other (specify): _____

GASTROINTESTINAL TRACT

- ☐ Heartburn/reflux/GERD
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Liver disease/cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Colon polyps
- ☐ Diverticulosis
- ☐ Bleeding problems
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Other (specify): _____

LUNGS

- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Recurrent pneumonias
- ☐ Other (specify): _____

KIDNEY & URINARY TRACT

- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Enlarged prostate
- ☐ Urinary incontinence
- ☐ Kidney stones
- ☐ Other (specify): _____

BONES & JOINTS

- ☐ Gout
- ☐ Lower back pain
- ☐ Osteoporosis
- ☐ Arthritis (indicate location):
  - ☐ hip
  - ☐ knee
  - ☐ shoulder
  - ☐ back
  - ☐ hands
- ☐ Fractured bone (indicate location):
  - ☐ hip
  - ☐ spine
  - ☐ wrist
  - ☐ Other (specify): _____

GLANDS

☐ Thyroid overactive (high)
☐ Thyroid overactive (low)

NERVOUS SYSTEM

☐ Epilepsy or seizures
☐ Parkinson's disease
☐ Other (specify): _____

OTHER HEALTH PROBLEMS

☐ Thrombosis/blood clots: ☐ in the leg ☐ in the lung
☐ Syncope (loss of consciousness)
☐ Sexual function problems (specify): _____
☐ Mental
☐ Cancer

- ☐ Breast
- ☐ Skin
- ☐ Prostate
- ☐ Lymphatic
- ☐ Colon/rectum
- ☐ Lung

☐ Other (specify): _____

☐ Genetic Disorders _____
☐ Diabetes
☐ OSA
☐ Restless leg
☐ Cerebral Palsy
☐ Stroke
☐ Neuropathy/nerve damage
☐ Head injury
☐ Play Contact Sports (football etc.)
☐ MVA car/motorcycle accident
☐ Other (specify): _____

15. HOSPITALIZATIONS/SKILLED NURSING VISITS

Please list all hospitalizations including neuropsychiatric hospitalizations.

Which Hospital/Skilled Nursing Facility?	Reason for Hospitalization/and outcome of visit	Year

15. PATIENT SOCIAL HISTORY

A. With whom do you live?
(Please check all that apply)

- ☐ Alone
- ☐ Spouse or Partner
- ☐ Child
- ☐ Other family member (specify):

  _____
- ☐ Others, not family (specify):

  _____

B. Which of the following best describes your residence?

- ☐ Single-family house
- ☐ Condo
- ☐ Apartment
- ☐ Board & Care/Assisted living
- ☐ Nursing Home
- ☐ Other (specify): _____

C. You are presently:

- ☐ Single/Never married
- ☐ Married
- ☐ Divorced/Separated
- ☐ Widowed
- ☐ Living with significant other

D. How many children do you have?

Number:_____

Are you in regular contact with at least one of your children?

☐ Yes ☐ No

E. How much school did you complete?

- ☐ Less than 8th grade
- ☐ High school
  Did you graduate? ☐ Yes ☐ No
- ☐ Some college
- ☐ College graduate
- ☐ Graduate school

F. Please specify your ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

  Specify: _____

G. Please specify your race
(Please check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Pacific Islander
- ☐ White
- ☐ Other _____

H. List your principal occupation and any other significant past occupations

1._____

2._____

3._____

Working

- ☐ Full time
- ☐ Part time
- ☐ Retired (year): _____
- ☐ Volunteer
- ☐ Other (specify): _____

I. Who would you (the patient) call if you were sick and needed help? (enter all that apply)

Name	Phone Number	Relationship	Permission to speak to this person on your behalf?
1.		☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other _____	☐ Yes ☐ No
2.		☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other _____	☐ Yes ☐ No
3.		☐ Spouse ☐ Neighbor ☐ Child ☐ Friend ☐ Other _____	☐ Yes ☐ No

J. Do you employ someone to provide health related care or help you in your home?

☐ Yes ☐ No

1. If yes, how many hours per day and days per week, is the paid helper available to you?

_____ Hours _____ Days per week (e.g. 3 hours, 5 days per week)

2. Is this sufficient to meet your needs? ☐ Yes ☐ No

K. Do you get help from family members or friends in your home? ☐ Yes ☐ No

1. If yes, how many hours per day and days per week, is the helper available to you?

_____ Hours _____ Days per week (e.g. 3 hours, 5 days per week)

2. Is this sufficient to meet your needs? ☐ Yes ☐ No

3. Please name family/friend who provides help: _____

4. If this family/friend were to get sick or hospitalized, who would provide help?

_____

L. Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

☐ Daily ☐ A few days a week (specify number of days: _____)

☐ Less than once a week ☐ Never

1. How much do you drink at a time? (One drink = 12 oz of beer or 8-9 oz of malt liquor or 5 oz. of table wine or 1.5 oz. of hard alcohol)

☐ 1 drink ☐ 2 drinks ☐ 3 drinks ☐ 4 drinks ☐ 5+ (how many? ___)

2. Has anyone ever been concerned about your drinking? ☐ Yes ☐ No

M. Have you ever used tobacco, smoked or vaped? ☐ Yes ☐ No

N. Have you ever used or abused drugs? ☐ Yes ☐ No

O. Do you currently exercise? ☐ Yes ☐ No

16. FAMILY HISTORY

A. Have any members of your family had memory problems? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

17. DRIVING

A. Do you have a active Driver's License? ☐ Yes ☐ No

B. If yes, are you currently driving? ☐ Yes ☐ No

C. Has anyone had concerns about your driving? ☐ Yes ☐ No

18. SAFETY

A. Do you always wear a seatbelt when you ride in a car? ☐ Yes ☐ No
B. Do you own any firearms? ☐ Yes ☐ No
C. Are there any firarms in your home? ☐ Yes ☐ No
D. Do you have a history of wandering or getting lost while outside of the home? ☐ Yes ☐ No
E. History of abuse? ☐ Yes ☐ No

19. PLANNING FOR FUTURE HEALTH CARE

Who should speak for you if you're unable to make health decisions?

Name: _____

Relationship: _____

Phone number: (_____) _____

Do you have a POA?

Name: _____

Relationship: _____

Phone number: (_____) _____

Do you have a living will/advance directive/out of hospital DNR form/POLST (PhysiciansOrders for Life Sustaining Treatment)? ☐ Yes ☐ No ☐ Unsure
If yes, please bring a copy

20. During the LAST 6 MONTHS have you had any of the following symptoms or problems?
(Please check all that apply)

A. General Problems

☐ Weight loss ☐ Weight gain
☐ Change of appetite ☐ Wandering

B. Ear, Nose, Mouth, Throat

☐ Trouble hearing
☐ Swallowing problems
Special diet? _____
Consistency? _____
☐ Teeth problems

C. Eyes

☐ Trouble seeing

D. Skin Problems

☐ Rash ☐ Ulcers
☐ Rash ☐ Ulcers

E. Lung Problems

☐ Cough when eating
☐ Difficulty breathing or shortness of breath

F. Mood/Sadness Problems

☐ Depression
☐ Anxiety
☐ Sleepliness
☐ Fatigue
☐ Lack of sleep

G. Heart Problems

☐ Chest pain or tightness
☐ Lightheadedness
☐ Irregular heart beat
☐ Rapid heart beat

H. Bone and Joint Problems

☐ Leg pain on walking
☐ Back or neck pain
☐ Joint pain or stiffiness
☐ Foot problems

I. Brain and Nervous System Problems

☐ Frequent headaches
☐ Frequent dizzy spells
☐ Falls
☐ Passing out or fainting
☐ Balance problems
☐ Paralysis, leg or arm weakness
☐ Numbness or loss of feeling
☐ Tremor or shaking
☐ Problems with sleep
☐ Hallucinations
☐ Delusions (false beliefs)

J. Digestive Problems

☐ Abdominal pain
☐ Constipation
☐ Frequent indigestion or heartburn
☐ Frequent nausea or vomiting
☐ Persistent constipation
☐ Frequent diarrhea
☐ Bleeding from rectum
☐ Black bowel movement

I. Kidney & Urinary Tract Problems

☐ Frequent urination
☐ Painful urination
☐ Difficulty starting or stopping urination
☐ Frequent urine infection
☐ Urination at night
If yes, how many times a night: _____
☐ Loss of urine or getting wet. If Yes:
- ☐ Sudden urge to void
- ☐ Loss with cough or laughing
- ☐ Continuous leakage
- ☐ Hard to start urination
- ☐ Cannot empty bladder
- ☐ Problem getting to toilet

21. Fall Risk

A. Do you use a walking aid such as a cane or a walker? ☐ Yes ☐ No

If yes, which ones? ☐ Cane ☐ Walker ☐ Wheelchair

B. Are you afraid of falling? ☐ Yes ☐ No

C. Have you had ☐ Yes ☐ No

If yes, please describe the circumstances surrounding the fall:

Did you trip over something?	☐ Yes	☐ No
Did you have light-headedness or palpitation prior?	☐ Yes	☐ No
Did you lose consciousness?	☐ Yes	☐ No
Were you injured?	☐ Yes	☐ No
Did you need to see a doctor?	☐ Yes	☐ No
Were you able to get up by yourself?	☐ Yes	☐ No

22. Access to Resources & Services

A. Is anybody outside of PSC helping you get information or services you need? ☐ Yes ☐ No

B. What outside services have you received in the past? *(List all)*

_____

_____

C. Please check the appropriate box for each service to indicate the service you are currently receiving and what services if any, you would be interested in receiving.

FOR CAREGIVERS: Caregiver Services

Currently receiving	Interested in receiving	
☐	☐	Respite or break for caregiver
☐	☐	Caregiver Support Group
☐	☐	Consultation or help in planning for board and care or assisted living placement
☐	☐	Hospice Care
☐	☐	Private In-Home care (privately paid caregiver)
☐	☐	In-Home Supportive Services (MediCal only program)

Day-To-Day Services

Currently receiving	Interested in receiving	
☐	☐	Transportation (e.g. subsidies, public, door-to-door services)
☐	☐	Nutrition Services (meal delivery, shopping, meal preparation)
☐	☐	Supplies (e.g. toiletries, clothing, etc.)
☐	☐	Housekeeping
☐	☐	Medications management
☐	☐	Adult Day Care services
☐	☐	Access to communication (e.g. TTY, instruments for the hearing impaired)
☐	☐	Work accommodation (e.g. flexible hours, job modification)
☐	☐	Home Health Care
☐	☐	Home safety modification (e.g. bathroom bars, commodes, etc.)

Social Services

Currently receiving	Interested in receiving	
☐	☐	Benefits Counselling (e.g. MediCare Part D, Supplemental Security Income, Social Security)
☐	☐	Financial counselling (e.g. money mgmt, debt or foreclosure counselling)
☐	☐	Social Work services
☐	☐	Housing services (e.g. subsidized housing, discrimination, landlord disputes, homelessness)
☐	☐	Care coordination
☐	☐	Veteran's services
☐	☐	Legal advocacy
☐	☐	Chaplain services

D. Financial Concerns: Do you have any concerns regarding patient finances (e.g. paying for caregiver)? Check all that apply.

_____ Yes, current concerns

_____ No concerns now, but maybe in the future

_____ No concerns at all

E. Legal Concerns: Do you have any legal concerns (e.g. conservatorship, advance directives)?

☐ Yes ☐ No

23. Please list specific health concerns that you would like us to know about before your visit.

Please be sure to include any information not already reported in this form.

1)

2)

3)

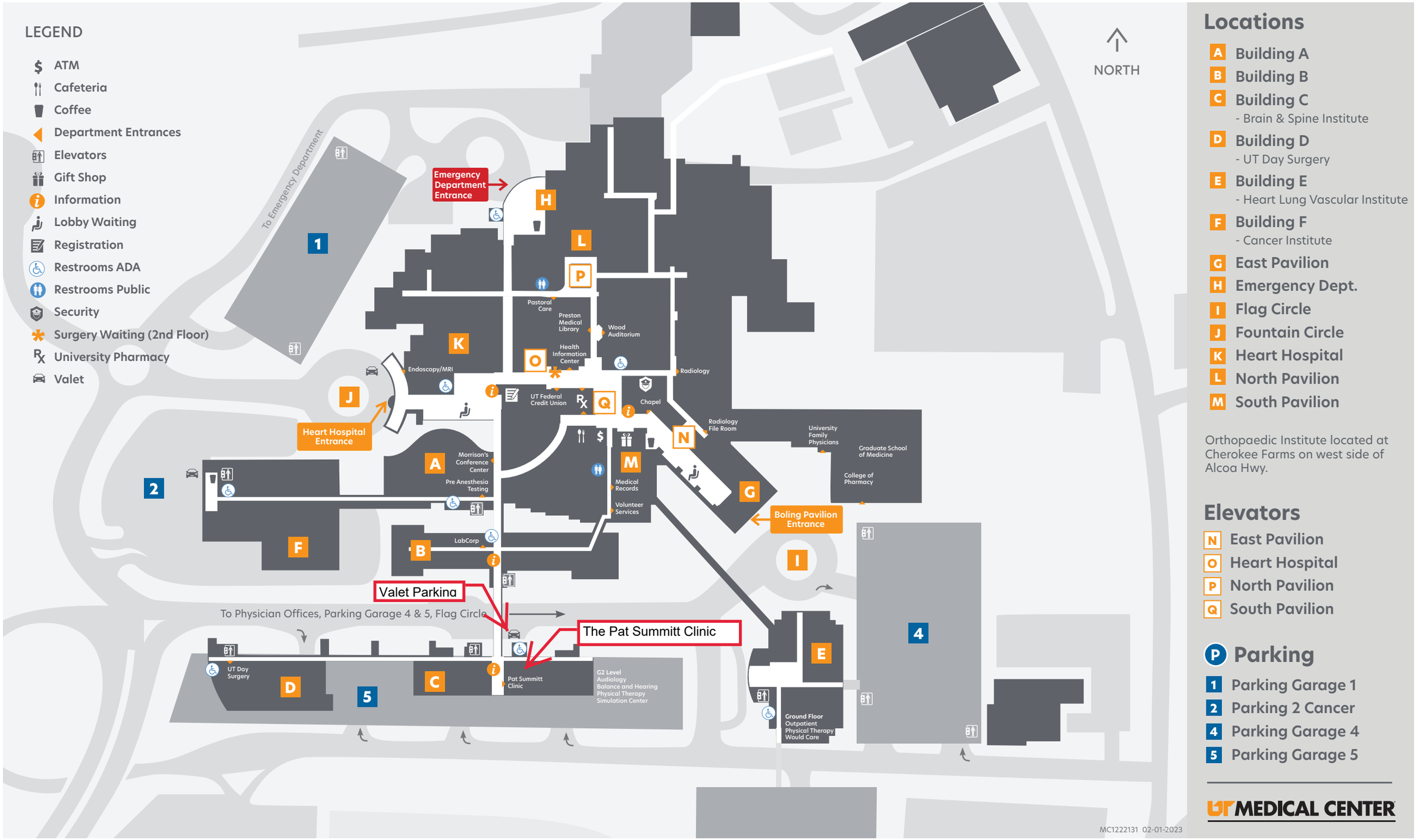
4)

5)

Would you be interested in participating in research studies?

☐ Yes ☐ No

THANK YOU FOR COMPLETING THIS FORM



Locations

- A Building A
- B Building B
- C Building C
  - Brain & Spine Institute
- D Building D
  - UT Day Surgery
- E Building E
  - Heart Lung Vascular Institute
- F Building F
  - Cancer Institute
- G East Pavilion
- H Emergency Dept.
- I Flag Circle
- J Fountain Circle
- K Heart Hospital
- L North Pavilion
- M South Pavilion

Orthopaedic Institute located at Cherokee Farms on west side of Alcoa Hwy.

Elevators

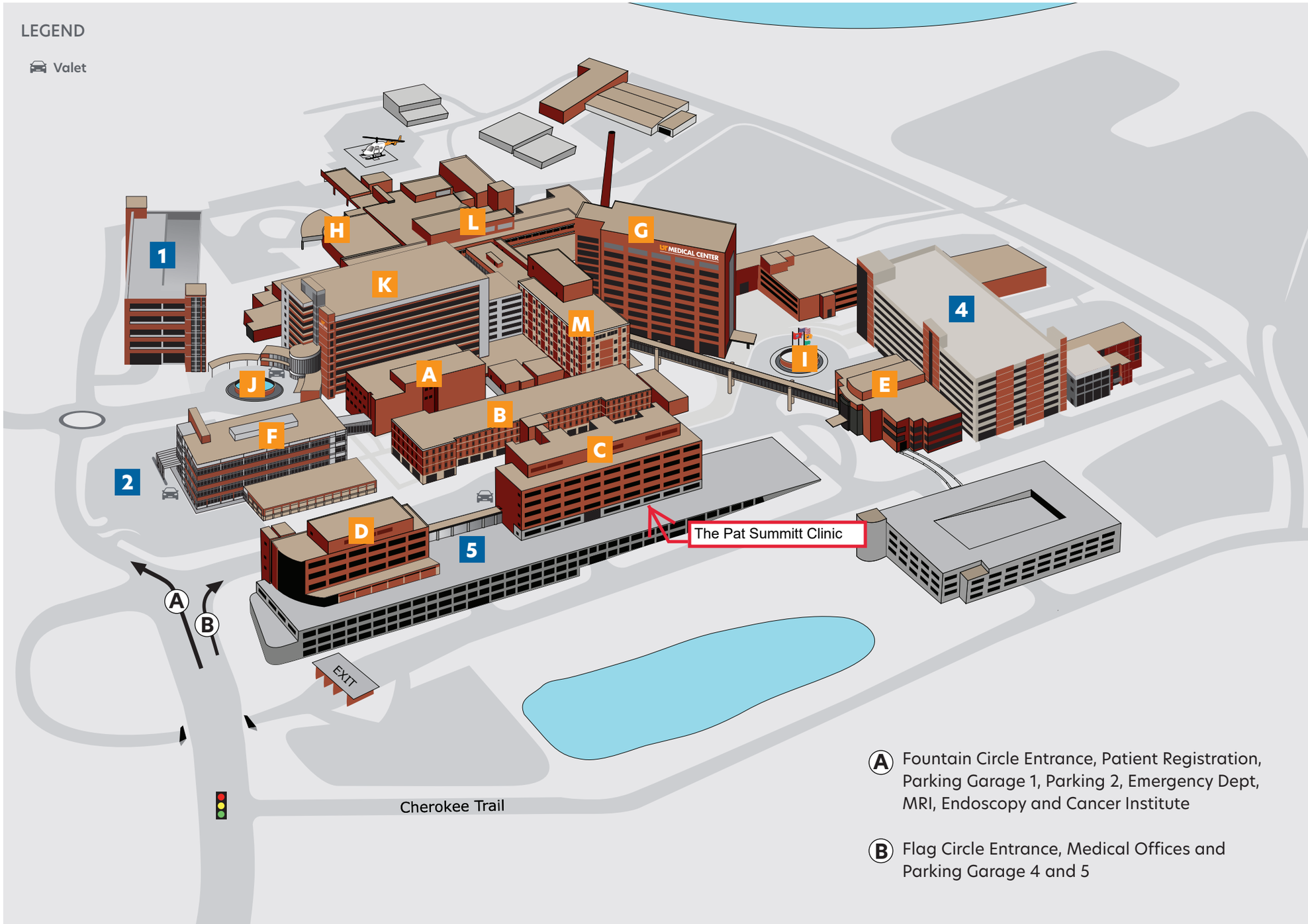
- N East Pavilion
- O Heart Hospital
- P North Pavilion
- Q South Pavilion

Parking

- 1 Parking Garage 1
- 2 Parking 2 Cancer
- 4 Parking Garage 4
- 5 Parking Garage 5

UT MEDICAL CENTER

MC1222131 02-01-2023



Ⓐ Fountain Circle Entrance, Patient Registration, Parking Garage 1, Parking 2, Emergency Dept, MRI, Endoscopy and Cancer Institute

Ⓑ Flag Circle Entrance, Medical Offices and Parking Garage 4 and 5

Locations

- A Building A
- B Building B
- C Building C
  - Brain & Spine Institute
- D Building D
  - UT Day Surgery
- E Building E
  - Heart Lung Vascular Institute
- F Building F
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- G East Pavilion
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Orthopaedic Institute located at Cherokee Farms on west side of Alcoa Hwy.

Parking

- 1 Parking Garage 1
- 2 Parking 2 Cancer
- 4 Parking Garage 4
- 5 Parking Garage 5

Important Numbers

Security
865-305-9540

Information Desk
865-305-9000

Outpatient Transport
865-305-2401

Shuttle Services
865-305-9544

Registration
865-305-9501