PATIENT REGISTRATION FORM

TODAY'S DATE:		
Last Name:	First Name:	Middle Name:
Suffix:	Preferred Name:	Date of Birth:
SSN:	Gender:	Preferred Language:
ADDITIONAL DEMOGRAPHICS		
Home Address:		
City:	State:	ZIP Code:
Home Phone: ( ) ---	Cell Phone: ( ) ---	Work Phone: ( ) ---

Do you want an invitation to Patient Portal? Y or N	Preferred Phone: ( ) ---
Email Address:	Primary Care Physician Name:
EMERGENCY CONTACT	
Emergency Contact Name:	
Relationship to Patient:	Home Phone:
Cell Phone:	Work Phone:
INSURANCE INFORMATION	
Subscriber Name:	Subscriber DOB:
Plan Name:	Member Number:
EMPLOYER INFORMATION	
Current Employer Name:	Phone:

Address:	City:	State:	Zip Code:

SIGNATURE

I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the physician and I understand that I am financially responsible for any balance. The above information is true to the best of my knowledge.

Patient/Guardian Signature:	Date:

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
- ☐ Prostate
- ☐ Colon/rectum
- ☐ Skin
- ☐ Lymphatic
- ☐ 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)

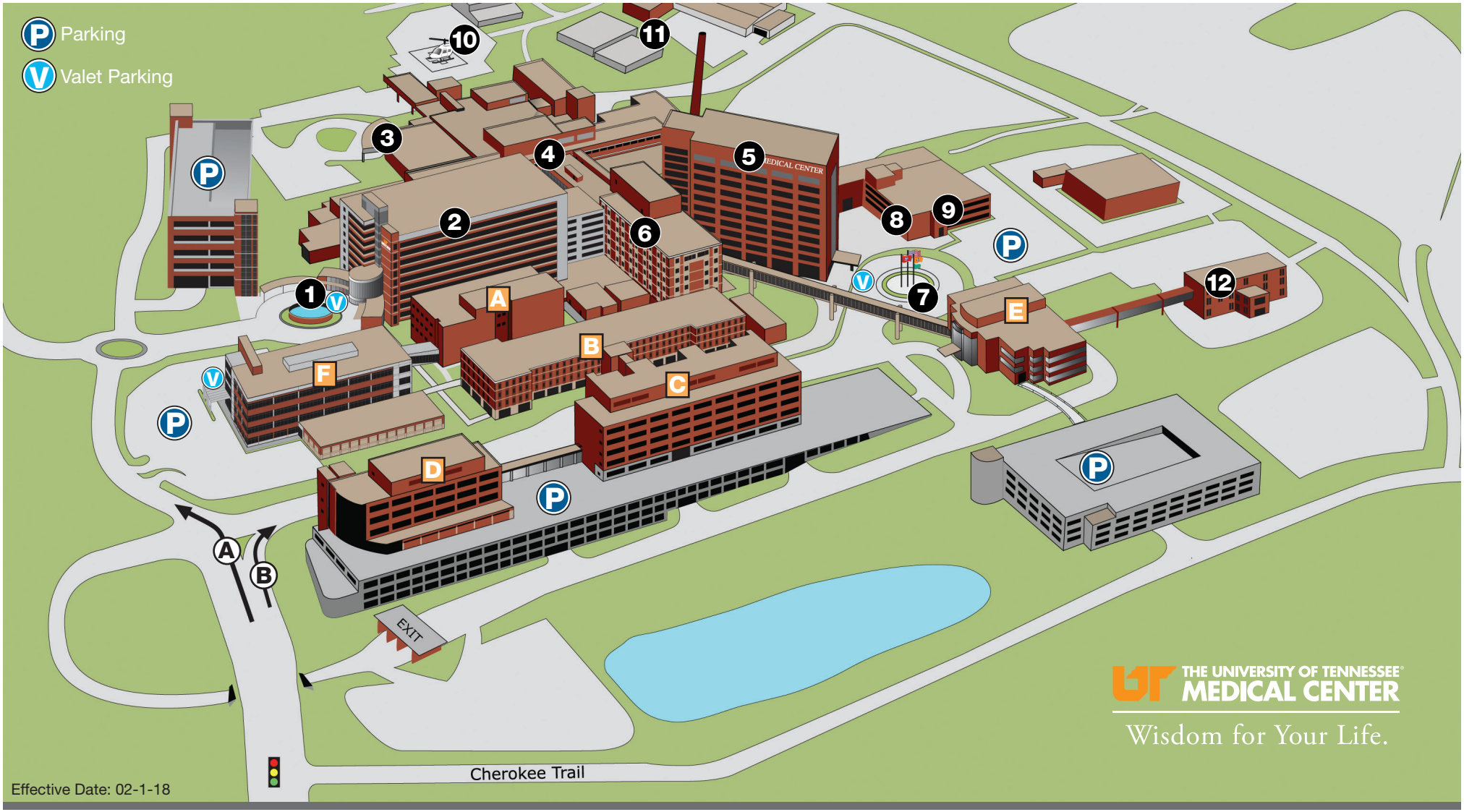
5)

Would you be interested in participating in research studies?

☐ Yes ☐ No

THANK YOU FOR COMPLETING THIS FORM


Destination
Information
Exit Stairs
Public Elevators
Public Restrooms
Surgery Waiting (Second Floor)
Valet Service
THE UNIVERSITY OF TENNESSEE MEDICAL CENTER
Wisdom for Your Life.
Facilities Planning
Modular Building
EMERGENCY Patient Drop-Off
To Emergency Department
Parking Garage H
EMERGENCY/ TRAUMA CENTER
Eye Bank
Pastoral Care
Health Information Center
Wood Auditorium
Heart Hospital
MRI/Endoscopy
Conference Center
Foutain Circle Entrance
Waiting
Patient Access Center
University Pharmacy
Security
Radiology
Chapel
Gift Shop
Medical Records
Volunteer Services
East Boling Patient Pavilion
Waiting
UT Graduate School of Medicine
University Family Physicians
College of Pharmacy
Flag Circle Entrance
Medical Building F
Cancer Institute Parking
Cancer Institute
Diagnostic Imaging
Breast Center
Radiation Oncology
Advanced Orthopaedic Center
Ortho Office & Education
Medical Building A
Morrison's Conference Center
Pre-Anesthesia Testing
Garden View Eatery (Cafeteria)
LabCorp (Patient Lab)
Medical Building B
To Physicians' Offices, Parking Garage and Boling Pavilion Entrance
UT Day Surgery
Medical Building D
Medical Building C
Brain and Spine Institute
Pat Summitt Clinic
Simulation Center
G2 Level Audiology, Balance and Hearing Physical Therapy
Parking Garage G
To Parking Garage
Medical Building E
Heart Lung Vascular Institute
Cherokee Trail Building
Ground Floor Outpatient PT, Wound Care,
Parking Garage E
Effective Date: 2-1-18
MC0119003



Route A: Parking Garage H, Emergency Dept, MRI, Endoscopy and Cancer Institute

Route B: To Hospital/Main Entrance, To Medical Offices and Parking Garage

1. Fountain Circle
2. Heart Hospital, Endoscopy Center, MRI
3. Emergency/Trauma
4. North Tower
5. East Boling Patient Pavilion
6. South Pavilion
7. Flag Circle
8. UT Graduate School of Medicine
   University Family Medicine
9. UT College of Pharmacy
10. UT LIFESTAR
11. Human Resources/Facilities Planning
12. Cherokee Trail Building

Medical Office Buildings

- A Medical Building A
- B Medical Building B
- C Medical Building C-*Brain and Spine Institute*
- D Medical Building D-*UT Day Surgery*
- E Medical Building E-*Heart Lung Vascular Institute*
- F Medical Building F-*Cancer Institute*
  Advanced Orthopaedic Center