CARE Center

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NEW PATIENT INFORMATION

Who is filling out this form? ☐ Patient ☐ Provider ☐ Care Partner ☐ Other:_______

Patient Name: ____

LAST FIRST M.I.

Birth Date: _____________________ **Current Age:** _________

Please check the response(s) that best fit you:

☐Male ☐Female ☐Intersex ☐Nonbinary ☐Transgender

☐Prefer not to respond ☐Other: ___________________________

Pronouns: ☐ he/him ☐ she/her ☐ they/them ☐ other: ____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Work Status/Occupation: ______________________________________

Highest Level of Education: ____________________________________

Handedness: ☐ Right ☐ Left ☐ Mixed (Ambidextrous)

Has the hand you primarily use changed because of injury? ☐ Yes ☐ No

With whom does the patient currently live: ____________________________________

Relation to the patient: ____________________________________

Race: ☐ African American/Black ☐ Asian ☐ American Indian or Alaska Native

☐ Native Hawaiian or other Pacific Islander ☐ White/Caucasian

☐ Other race or multi-racial (please specify): ____________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Primary Language:** ___________________

Primary Phone Number: _____________________________ **Type:** Cell / Home / Work

Secondary Phone Number: _____________________________ **Type:** Cell / Home / Work

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Email: ____

Street Address: ____

City: ______________________________ **State:** _______________ **Zip:** ____________

Mailing Address *(if different from above)*: _________________________________

City: ______________________________ **State:** _______________ **Zip:** ____________

CARE PARTNER INFORMATION (IF APPLICABLE)

Care Partner Name: ____

LAST FIRST M.I.

Pronouns: ☐ he/him ☐ she/her ☐ they/them ☐ other: ___________

Relation to Patient: __________________________________

Primary Phone Number: __________________________ **Type:** Cell / Home / Work

Secondary Phone Number: __________________________ **Type:** Cell / Home / Work

Email: ____

Street Address: ____

City: ______________________________ **State:** _______________ **Zip:** ____________

Is the Care Partner also the patient's emergency contact?

☐ Yes ☐ No

If no, please fill out the following information regarding the patient's emergency contact.

Emergency Contact:

Name: ___________________________________ **Phone #:** ____________________________

Relation: ________________________________

Does the patient have a Legally Authorized Representative (e.g., Power of Attorney)?

☐ Yes ☐ No

If yes, please provide the name and contact information for the Legally Authorized Representative.

Name: ___________________________________ **Phone #:** ____________________________

Relation: ________________________________

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PATIENT'S MEDICAL HISTORY

Please check all that apply to the patient **OR** ☐ None Apply

Neurological

- Concussion(s)/loss of consciousness from head impact
- Dizziness or Fainting
- Headache
- Multiple Sclerosis
- Neuropathy
- Parkinson's Disease or other movement disorder
- Polio
- Seizures

Sensory

- Blindness or Low Vision
- Cataracts
- Glaucoma
- Hearing Loss
  - Hearing Aids
- Macular Degeneration

Heart Disease & Stroke Risk Factors

- Heart Attack
- Atrial Fibrillation
- Congestive Heart Failure
- Cardiac Stent
- Pacemaker
- History of stroke or TIA
- High Blood Pressure
- High Cholesterol
- Other vascular stent

Psychiatric

- Alcohol or other substance use disorder
- Anxiety
- Delusions
- Depression
- Hallucinations
- Other (specify): ________________

Blood-Based Illnesses

- Sickle Cell Disease/Trait
- Hepatitis A / B / C
- Anemia
- Other (specify): ________________

Sleep

- Insomnia
- Restless Leg Syndrome
- Acting out dreams
- Sleep apnea
- Other (specify): ________________

Hormones

- Thyroid Disease
- Hormone Replacement Therapy
- Pituitary Illness

Immune/Autoimmune

- Lupus or other autoimmune disease
- HIV/AIDS
- Other (specify): ___________________

Respiratory

- Emphysema
- COPD
- Pneumonia
- Tuberculosis
- Asthma

Musculoskeletal

- Arthritis
- Osteoporosis
- Other (specify): ___________________

Other

- Colitis/Chron's Disease
- Diabetes
- Cancer (Type: ____________________)
- Kidney Disease
- Liver Disease
- Loss of bowel/bladder control
- Trouble walking
- Trouble with balance

Other: ____________________________________

____

Has the patient ever had evaluations for memory problems or possible dementia?

☐ Yes ☐ No

If yes, please describe: ____

Has the patient ever received a diagnosis in relation to your symptoms?

☐ Yes ☐ No

If yes, please describe: ____

Has the patient ever had surgery? ☐ Yes ☐ No

Date: _____________ Procedure: ____

Date: _____________ Procedure: ____

Date: _____________ Procedure: ____

Date: _____________ Procedure: ____

Has the patient ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No

Date: _____________ Reason: ____

Date: _____________ Reason: ____

Date: _____________ Reason: ____

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Date: _____________ Reason: ____

HEALTH HABITS

Cigarette/Cigar Use:

☐ Yes, currently: Year started _____________ Packs per day: _______

☐ Yes, in the past: Year stopped ____________ Packs per day: _______

☐ No

Current Alcohol Use: _________ drinks per day/week/month (circle one) **OR** ☐ None

Smokeless Tobacco Products: ☐ Yes ☐ No

Recreational Drug Use: ☐ Yes, currently ☐ Yes, in the past ☐ No

Current Caffeine Use (check all that apply):

Soda
Tea
Coffee
Energy Drinks
Caffeine Pills
Other: __________________

Does the patient exercise? ☐ Yes ☐ No

How often? ________________/week

For how long? ____________ minutes/hours (circle one)

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FAMILY HEALTH HISTORY

Please check all that apply to the patient's <u>biologically related</u> family members:

Alzheimer's Disease or other dementia
Cancer
Psychiatric Illness (specify, if known: _________________________)
Stroke
Tremor/Parkinson's Disease
Other movement disorder (specify, if known: _________________________)
No family history of the above disorders

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PRESCRIPTION MEDICATIONS

Please list all current prescription medications; indicating dosage, frequency and method.

Name	Dosage	Frequency	How it's taken

Have you ever been prescribed "memory medications" such as:

Aricept/Donepezil
Exelon/Rivastigmine
Namenda/Memantine
Razadyne/Galantamine

Please list the reason for discontinuation of any of these medications, if appropriate.

Medication Name	Reason for discontinuation

OVER-THE-COUNTER MEDICATIONS, HERBALS, AND SUPPLEMENTS

Please list all other medications, herbals and supplements; indicating name, dosage, frequency and reason for taking (if applicable).

Name	Dosage	Frequency	Reason (if applicable)

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PHARMACY INFORMATION

Please list the pharmacy or pharmacies that you regularly use to fill your prescriptions:

Pharmacy Name	Address	Phone Number

ALLERGIES AND ADVERSE REACTIONS

Please list all medications you are allergic to or have an adverse reaction to OR ☐ None

Name	Reaction

Please list any other allergies or sensitivities OR ☐ None

Name	Reaction

The CARE Clinical Team includes a pharmacist. Do you have any questions or concerns regarding your medications that you would like to speak with the Pharmacist about?

☐ Yes (please explain): ____

☐ No

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PRIMARY CARE PROVIDER

Provider's Name: ____

Name of Practice: ____

Phone Number: _________________________ **Fax:** _________________________

Street Address: ____

City: ___________________________ **State:** ________________ **Zip:** _____________