INITIAL VISIT QUESTIONNAIRE

Memory Care Specialists
3231 Gulf Gate Dr. Suites 203 A&B
Sarasota, FL 34231

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Soc. Sec. #: _____

PHYSICIAN INFORMATION:

Who is your Primary Care Physician? Date of last visit: _____ Name:

_____

Address: _____

Phone: _____

Please list other doctors that you are seeing or have seen in the past.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

PHARMACY INFORMATION:

Preferred Pharmacy Name: _____

Pharmacy Phone Number: _____

Secondary Pharmacy Name: _____

Pharmacy Phone Number: _____

Other Pharmacy info: _____

Name: _____ Date: _____

ALLERGIES:

_____

_____

_____

PAST MEDICAL HISTORY: Circle any of the following that you have had.

Allergies or Asthma	Congestive Heart Failure	Hemorrhoids	Migraines
Alcoholism	Depression	Hepatitis (Jaundice)	Phlebitis
Anemia	Diabetes	High Blood Pressure	Psoriasis
Arthritis	Drug Abuse	Heart Blockage	Hernia
Breast lumps/cysts	Eczema-Hives	Kidney Stones	Stroke
Cancer (Tumors)	Epilepsy or Seizures	Liver Disease	Suicide Attempt
Cataracts	Heart Attack	Lung Disease	Thyroid Disease
Blood Clot	Glaucoma	Macular Degeneration	High Cholesterol

Other: _____

_____

_____

PAST SURGICAL HISTORY:

Ear or eye surgery Year(s) _____

Skin lesion removal Year(s) _____

Heart surgery Year(s) _____

Lung surgery Year(s) _____

Appendix Year(s) _____

Gall bladder Year(s) _____

Hysterectomy Year(s) _____

Ovaries Year(s) _____

Prostate Year(s) _____

Stomach surgery Year(s) _____

Bowel surgery Year(s) _____

Joint surgery Year(s) _____

Other _____

_____

Name: _____ Date: _____

MEDICATIONS: [List all current drugs, the dosage (strength), and how often you take it.]

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

SOCIAL HISTORY:

Tobacco Use: Cigarettes: Y N Cigars: Y N Pipe: Y N

For cigarettes, how many packs per day do you smoke? _____

For cigars or pipe, how much per day? _____

If you do not smoke, have you ever smoked? _____ How long ago did you quit? _____

Alcohol: Number of drinks _____ Daily / Weekly / Monthly

Drugs: Have you ever used injectable drugs? Y N

Marital Status: Are you married? _____ If so, for how long? _____

Children: How many children do you have? _____ How is their health? _____

_____

_____

Name: _____ Date: _____

FAMILY HISTORY:

Please check off conditions in your family:

Condition	Mother	Father	Grand-parents	Sibling	Aunt/Uncle	Other
Heart						
High blood pressure						
Stroke						
Diabetes						
Lung problems						
Thyroid						
Kidney						
Stomach						
Bowel						
Anxiety						
Depression						
Dementia						
Cancer						

Other: _____

_____

_____

Do you have a living will? Y N If yes, may we have a copy? Y N

Have you designated a health care surrogate or someone to make medical decisions for you in the event that you cannot make decisions for yourself? Y N

If yes, please provide Name: _____

Phone number(s): _____

Do you have a signed Do Not Resuscitate (DNR) form? If yes, may we have a copy? Y N

The information above was reviewed with the patient. Physician: _____

Name: _____ Date: _____

Review of Systems

Do you have any ongoing or current symptoms listed below? Check either "Yes" or "No" for each.

Constitutional		**Genitourinary**	
Weight Loss or Gain	☐ Yes ☐ No	Blood in your urine	☐ Yes ☐ No
Appetite changes (increased or decreased)	☐ Yes ☐ No	Menstrual changes	☐ Yes ☐ No
Fatigue, profound and impairs daily function	☐ Yes ☐ No	Urinating that is painful or difficult	☐ Yes ☐ No
Fever or chills	☐ Yes ☐ No	Erection problems	☐ Yes ☐ No
Shakes/sweats from lack of alcohol or drug	☐ Yes ☐ No	Vaginal discharge or bleeding	☐ Yes ☐ No
Eyes		**Musculoskeletal**	
Eye pain or drainage	☐ Yes ☐ No	Broken bones	☐ Yes ☐ No
Visual changes	☐ Yes ☐ No	Joint pain or swelling	☐ Yes ☐ No
Dry, irritated eyes	☐ Yes ☐ No	Muscle aches	☐ Yes ☐ No
ENT/Mouth		Muscle weakness	☐ Yes ☐ No
Ear pain or drainage	☐ Yes ☐ No	Back pain	☐ Yes ☐ No
Frequent sinus infections	☐ Yes ☐ No	**Skin/Breasts**	
Hearing changes or loss	☐ Yes ☐ No	Masses or lumps	☐ Yes ☐ No
Nosebleeds	☐ Yes ☐ No	Nipple discharge	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Rashes or nonhealing ulcers	☐ Yes ☐ No
Respiratory		**Neurologic**	
Blood in your sputum	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Chest tightness	☐ Yes ☐ No	Coughing or choking with	☐ Yes ☐ No
Cough lasting >1 month (productive or not)	☐ Yes ☐ No	Excessive daytime sleepiness	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Extremity pain or burning	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Hallucinations	☐ Yes ☐ No
Chest pain with inhalation or coughing	☐ Yes ☐ No	Numbness or tingling	☐ Yes ☐ No
Cardiovascular		Difficulty falling asleep, staying	☐ Yes ☐ No
Chest pain or heaviness	☐ Yes ☐ No	**Endocrinologic**	
Palpitations	☐ Yes ☐ No	Hair loss	☐ Yes ☐ No
Fainting or near fainting spells	☐ Yes ☐ No	Frequent urination	☐ Yes ☐ No
Swelling of feet or legs	☐ Yes ☐ No	Increased thirst	☐ Yes ☐ No
Shortness of breath lying flat in bed	☐ Yes ☐ No	Heat or cold intolerance	☐ Yes ☐ No
Gastrointestinal		Hot flashes or night sweats	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	**Heme/Lymph**	
Blood in your stool	☐ Yes ☐ No	Bleeding from gums or nose	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Unexplained bruising	☐ Yes ☐ No
Diarrhea or Food Intolerance	☐ Yes ☐ No	Swollen, painful lymph nodes	☐ Yes ☐ No
Heartburn or Indigestion	☐ Yes ☐ No	**Allergy/Immun**	
Vomiting or nausea lasting for >1 day	☐ Yes ☐ No	Watery eyes	☐ Yes ☐ No
Swallowing difficulty	☐ Yes ☐ No	Runny nose	☐ Yes ☐ No
Psych		Food intolerance	☐ Yes ☐ No
Anxiety without clear explanation	☐ Yes ☐ No	Frequent skin sores	☐ Yes ☐ No
Sadness lasting for days or weeks	☐ Yes ☐ No	**Other**	
Hearing voices	☐ Yes ☐ No	Do you exercise	☐ Yes ☐ No
Thoughts of hurting yourself	☐ Yes ☐ No	Do you eat red meat	☐ Yes ☐ No
Thought of hurting others	☐ Yes ☐ No	Do you take supplements	☐ Yes ☐ No
Fear of people, places or things	☐ Yes ☐ No	If yes, have supplements changed	☐ Yes ☐ No

The information above was reviewed with the patient. Physician: _____