UNT | HEALTH SCIENCE CENTER

CENTER FOR GERIATRICS

Geriatric Assessment and Planning Program

Dear New Patient and /or Caregiver,

The UNTHSC Center for Geriatrics welcomes you to our practice. We are pleased that you have chosen us for your healthcare needs. Our board-certified geriatricians, nurse practitioners, nurses, neuropsychologists and social service coordinators are committed to improving the physical and mental function of our patients, with a focus on improving and maintaining their quality of life.

Your Appointment is with_____on_____.

Please arrive for your appointment at_____to complete your registration.

If you are unable to keep your appointment, please call us in advance: 817-735-2200

The Geriatrics Clinic is located on the **4th Floor** of the Patient Care Center on the UNT Health Science Center campus. We have included a map and parking directions.

What to expect during your appointment?

During the first appointment, the patient and his/her family will be seen by a number of staff members. Because we make a complete assessment of each patient's physical, psychological and social condition, it is not unusual for a physician, a social worker, a nurse, and other members of the clinic staff to take part in the examination. Since we are a teaching University, we often have Students, Resident Doctors and Fellows in addition to other health care professional students assisting in the clinic under an attending physician's supervision.

We ask that you review and complete the enclosed New Patient Checklist and Medical Health History form prior to your appointment. Also, in preparation for your appointment, you will be contacted by a Social Worker who will obtain social health history information.

We look forward to seeing you soon.

Thank You,

Center for Geriatrics
GAPP Clinic (Geriatric Assessment & Planning Program)

855 Montgomery Street, Patient Care Center, 4th Floor, Fort Worth, TX 76107
817-735-2200

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New Patient Checklist

- ☐ **Complete** Authorization for Release of Health Information form and mail, fax, or deliver to your Physicians, so we can have your health information prior to your visit.
- ☐ **Complete** the enclosed medical history form and bring them to the visit.
- ☐ **Bring** all medications in the enclosed brown bag.
- ☐ **Bring** Medical Power of Attorney & Directive to physician forms (if applicable) A copy is needed for our records.
- ☐ **Bring** proof of insurance including your Medicare card and supplemental insurance card.
- ☐ **Bring** a calendar and a notepad for scheduling and note taking.
- ☐ **If** you are changing your Primary Care Physician (PCP) to a UNT provider- Please contact your insurance carrier to change PCP to the physician you are seeing.

  If you are insured through a HMO, you must obtain a referral from you PCP and authorization from your insurance company is required.
- ☐ **Expect** a call from the Social Worker, who will obtain your social history prior to your visit.
- ☐ **Be prepared** for approximately a **<u>two to three hour</u>** new patient office visit.

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Medical Health History Form

Patient Name: **Today's Date:** **Age:**

Years of Education/Highest Degree:

Who lives at home with you?

Martial Status: (Circle) Single Married Partner Divorced Widowed **Number of Children:**

How would you rate your general health: (Circle) Excellent Good Fair Poor

MEDICAL AND PREVENTATIVE HEALTH

Name of Primary Care Physician:

Please provide the date of last exam or procedure

Complete Physical: **EKG:** **Chest X-Ray:**

Brain CT/MRI scan: **Flexible Sigmoidoscopy/Colonoscopy:**

Hearing Exam: **Eye Exam:** **Dental Exam:**

Tuberculosis Skin Test: **Reaction:(y/n)** **HIV Test:**

Women's Health: **Pelvic /Pap smear:** **Mammogram:**

Men's Health: **Prostate Exam:**

Vaccinations

Pneumonia Shot: **Shingles Shot:**

Tetanus Shot: **Flu Shot:**

PLEASE PROVIDE NAME AND SPECALITY OF ALL PHYSICIANS YOU SEE

Name	Specialty	Phone

MEDICATION ALLERGIES: List medication(s) you are allergic to and what reaction(s) you have

Medication Name	Reaction

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Medical Health History Form

CURRENT MEDICATIONS: List all medications, including prescribed medications, over-the counter medications, supplements, vitamins, and homeopathic/natural

Medication Name	Dose/How Often	Prescribing Doctor's Name	Refill Needed (y/n)

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Medical Health History Form

PAST MEDICAL HISOTRY

Please check the appropriate boxes below if you have ever been diagnosed or experienced any of the following:

☐ Pneumonia	☐ Diabetes	☐ Tuberculosis
☐ Bronchitis	☐ Heart attack	☐ Hepatitis
☐ Cancer: type _____	☐ Angina	☐ Thyroid problems
☐ Stomach/intestinal ulcers	☐ Gall stones	☐ Gout
☐ Kidney stones	☐ Seizures	☐ Strokes
☐ Blood clots/phlebitis	☐ Cataracts	☐ Glaucoma
☐ Hernias: type _____	☐ High cholesterol	☐ Pancreatitis
☐ Irregular heart rhythm	☐ Diverticulosis	☐ Kidney failure
☐ Migraine headaches	☐ Arthritis	☐ Mental illness
☐ Parkinson's disease	☐ High blood pressure	☐ Asthma/emphysema
☐ Sexually transmitted disease		

Obstetric History

Number of pregnancies: _____ Number of live births: _____

LIST ALL HOSPITILIZATIONS, SURGERIES AND SERIOUS ACCIDENTS

Please, include year and place treated

_____

_____

_____

_____

_____

_____

_____

_____

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FAMILY HEALTH HISTORY

Relation		Age if living	Age at death	Major Health Problems			Cause of Death	
FATHER								
MOTHER								
SIBLINGS								

REVIEW OF SYSTEMS

Please check the box of any of the following that you have experienced recently

GENERAL

- ☐ Chills
- ☐ Malaise
- ☐ Weight gain
- ☐ Increased appetite
- ☐ Fatigue
- ☐ Night sweats
- ☐ Weight loss
- ☐ Decreased appetite
- ☐ Fever
- ☐ Other _____

HEAD, EYES, EARS, NOSE THORAT

- ☐ Ear drainage
- ☐ Sore throat
- ☐ Wear glasses/contacts
- ☐ Ear pain
- Visual changes
- Hearing loss
- ☐ Eye discharge
- ☐ Seeing halos around light
- ☐ Ringing/Buzzing in ears
- ☐ Eye pain
- Double vision
- Wear dentures/partials
- ☐ Hearing loss
- ☐ Persistent hoarseness
- Sore gums
- ☐ Nasal drainage
- Jaw pain
- Dry mouth
- ☐ Sinus pressure
- Bloody nose
- Tooth aches
- ☐ Sores in mouth
- ☐ Difficulty swallowing

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Medical Health History Form

LUNGS

- ☐ Persistent cough
- ☐ TB exposure
- ☐ Coughing up blood
- ☐ Cough
- ☐ Shortness of breath
- ☐ Difficulty breathing when laying down
- ☐ Other _____

CARDIOVASCULAR

- ☐ Chest pain/pressure with exertion
- ☐ Ankle swelling
- ☐ Rapid heart beats
- ☐ Leg cramps with walking
- ☐ Passing out/faintness
- ☐ Irregular heart rhythm
- ☐ Other _____

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Loss of appetite
- ☐ Difficulty swallowing/chokes
- ☐ Blood in stools
- ☐ Loose stool/Diarrhea
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Change in stools
- ☐ Heartburn
- ☐ Food intolerance
- ☐ Black tarry stools
- ☐ Bloating/gas
- ☐ Hemorrhoids
- ☐ Other _____

UNINARY

- ☐ Pain/burning on urination
- ☐ Difficulty emptying bladder
- ☐ Blood in urine
- ☐ Difficulty starting urination
- ☐ Frequent urination
- ☐ Dribbling after urination
- ☐ Incontinence of urine
- ☐ Decrease in force of stream
- ☐ Kidney/bladder infections
- ☐ Leak urine when cough/sneeze
- ☐ Having to get to toilet quickly
- ☐ Repeated nighttime urination
- ☐ Difficulty making it to bathroom before urine leaks

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GENITALIA

Male	Female
☐ Penis Discharge	☐ Vaginal discharge/Itching
☐ Penis Sores	☐ Vaginal bleeding
☐ Testicle Mass	☐ Painful sex or sexual difficulties
☐ Impotence	☐ Pelvic pain
☐ Other _____	☐ Other _____

BREAST

☐ Masses/Lumps ☐ Bleeding ☐ Pain

☐ Nipple discharge ☐ Change in size ☐ Other _____

SKIN, HAIR, NAILS

☐ Hair changes ☐ Itchy skin ☐ Dry skin ☐ Rash

☐ Nail changes ☐ Mole changes ☐ Skin Lesion

☐ Skin infection/wound ☐ Other _____

ENDOCRINE

☐ Intolerance to heat ☐ Intolerance to cold ☐ Excessive thirst

☐ Excessive hunger ☐ Excessive urination ☐ Other _____

MUSCULAROSKELETAL

☐ Back pain ☐ Muscle weakness ☐ Easily broken bones ☐ Fall in the last 6 months

☐ Joint pain ☐ Neck Pain ☐ Difficulty walking ☐ Fall with injury

☐ Joint swelling ☐ Joint stiffness ☐ Muscle aches ☐ Other _____

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HEMATOLOGY

- ☐ Prolonged bleeding
- ☐ Bruising easily
- ☐ Blood transfusions
- ☐ Transfusion reaction
- ☐ Other _____

IMMUNOLOGIC

- ☐ Contact/Skin allergies
- ☐ Food allergies
- ☐ Seasonal allergies
- ☐ Environmental allergies
- ☐ Other _____

Please list or comment below anything else that is of concern to you or that you feel we should know:

Please list your main concerns and goals for this geriatric evaluation: