UAB MEDICINE
THE KIRKLIN CLINIC OF UAB HOSPITAL

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date of Service: _____
Physician: _____

Filling out this form will help us provide the best possible care for you.

What are the main questions or problems you would like help with?

1. _____

_____

_____

_____

2. _____

_____

_____

_____

3. _____

_____

_____

_____

IMPORTANT

PLEASE BRING A COMPUTER DISK WITH ANY BRAIN SCANS OR MRIs WITH YOU TO YOUR APPOINTMENT. You can get this from wherever the scan or MRI was done.

Doctor's offices do not send this information with your medical records.

Thank you!

UAB MEDICINE
THE KIRKLIN CLINIC OF UAB HOSPITAL

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date of Service: _____
Physician: _____

Do you have, or have you had any of the following? Please check "Yes" for all that apply.

	Yes	No		Yes	No
GENERAL			**NEUROLOGICAL**		
Change in Appetite			Headache		
Change in Weight			Neck Pain/Stiffness		
Change in Sleep			Fatigue		
Fever / Chills			Heat or Cold Sensitivity		
PSYCHIATRIC			Passing out		
Depression			Loss of memory		
Suicidal thoughts			Change in Personality		
Anxiety/Panic Attacks			Odd behaviors		
Mood swings/Irritability			Dizziness		
CARDIOVASCULAR			Ringing in the ears		
Chest Pain			Double vision		
Palpitations			Visual Blurring/Loss		
Shortness of breath			Difficulty swallowing		
Swelling around ankles			Slurred speech		
RESPIRATORY			Weakness of the Face		
Shortness of Breath			Numbness of the Face		
Cough			Tingling down the back		
Wheezing			Tingling down arm or leg		
GASTROINTESTINAL			Tight band around waist or chest		
Nausea/Vomiting			Muscle Weakness		
Stomach Pain			Muscle Stiffness / Spasms		
Heartburn			Muscle Cramps		
Bleeding from bowels			Tingling		
GENITOURINARY			Numbness		
Discomfort on passing urine			Other Pain		
Blood in urine			Incoordination		
DERMATOLOGIC			Tremor		
Rashes			Problems with walking or balance		
Changes in skin color			Urinary Frequency		
RHEUMATOLOGIC			Urinary Urgency		
Joint Pain/Stiffness			Urinary Incontinence		
Low Back Pain			Urinary Hesitancy		
Neck Pain			Bowel Urgency		
Muscle aches			Bowel Incontinence		
EAR, NOSE AND THROAT			Constipation		
Sinus Symptoms			Decreased Libido		
Decreased Hearing			Erectile/Ejaculatory problem		
Ear Pain / Discharge			Vaginal dryness		

Reviewed by: _____ **date:** _____

UAB MEDICINE
THE KIRKLIN CLINIC OF UAB HOSPITAL

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date of Service: _____
Physician: _____

What are your goals for today's visit? (Circle all that apply.)

Establish a diagnosis | Get Second Opinion
Discuss Treatment Options | Take part in research studies

Other: _____

Please circle the CURRENT problems: (Circle all that apply.)

Memory Loss | Loss of daily function (e.g. cooking, bill-paying, etc) | Behavior Change
Anxiety | Depression | Agitation/Irritability | Speech changes
Other (please describe) _____

What was the VERY FIRST problem that came up?

Memory Loss | Loss of daily function (e.g. cooking, bill-paying, etc) | Behavior Change
Anxiety | Depression | Agitation/Irritability | Speech changes
Other (please describe) _____

WHEN did these problems begin? _____

Has the patient ever had any brain scans, e.g. MRI or CT? No Yes (If yes, please bring images on a CD to appointment.)

Does the patient have, *or have they been treated for* any of the following? (Circle all that apply)

Stroke | High Blood Pressure | High Cholesterol | Diabetes | Sleep Apnea
Depression | Anxiety/Nerves | Past Head Injury/Concussion (if yes, how many?) _____

How much education has the patient completed? (Circle the best answer)

8 or less years | Some High School | High School/GED | Trade School | Some College
2 yr College Degree | 4 yr College Degree | Some Grad School | Graduate/Professional Degree

UAB MEDICINE
THE KIRKLIN CLINIC OF UAB HOSPITAL

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date of Service: _____
Physician: _____

What kind of work did the patient do for most of his/her adult life? _____

Is the patient retired? Circle: No Not applicable Yes (if yes, when?) _____

Does the patient smoke, now? No Yes

Did he/she smoke in the past? No Yes How much? _____ (packs a day)

How many years did he/she smoke? _____

When did he/she quit? _____

Does the patient drink any form of alcohol now? No Yes

What kind? Beer Wine Liquor

How often? Most Days 1-3 times/week 1-3 times/month less than 1/month

Did he/she drink alcohol in the past? No Yes

If yes, did he/she give it up for health reasons or on a doctor's advice? Yes No

Family Health Conditions

Place **X's** in the boxes to show if any family members (blood relatives) had any of the problems listed

	Memory Loss	Alzheimer's or Dementia	Strokes	Parkinson's	Depression or other Mental Illness	Other Brain Disease
Mother						
Father						
Brother						
Sister						
Aunt/Uncle						
Grandparent						
Other						

UAB MEDICINE

THE KIRKLIN CLINIC OF UAB HOSPITAL

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Date of Service: _____

Physician: _____

UAB HEALTH SYSTEM

UAB Health System – University Hospital, The Kirklin Clinic, The Kirklin Clinic at Action Road, UAB Heath Centers, the University of Alabama Health Services Foundation P.C. (Health Services Foundation), UAB Highlands, physicians who are on the UAB Health System Medical and Dental Staff pursuant to the UAB Health System Medical and Dental Staff Bylaws, and physicians who are on the UAB Highlands Medical Staff pursuant to the UAB Highlands Medical Staff Bylaws.

MEMORY DISORDERS CLINIC AUTHORIZATION TO SHARE MEDICAL INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below. This Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal privacy regulations.

Patient's Name:	**Family Caregiver's Name:**
Patient's Date of Birth:	**Caregiver's relationship to patient:**
Patient's Address:	**Caregiver's Address:**
City:	**City:**
State: **Zip:**	**State:** **Zip:**
Best phone number:	**Caregiver's best phone number:**
Cell number:	**Caregiver's cell number:**

Person/Organization providing the information	**Name, relationship & cell phone number of person(s) with whom my medical information may be discussed, including physicians**
Physicians and Staff of the University of Alabama at Birmingham	
The Kirklin Clinic Neurology Memory Clinic 2000 6th Ave. South Birmingham AL 35233 Phone: 205-801-8986	
Memory Disorders and Behavioral Neurology 1720 7th Ave. South, Sparks Center 620 Birmingham, AL 35294-0017 Phone: 205-99MEMRY (205-996-3679) Fax: 205-975-7365	

UAB MEDICINE
THE KIRKLIN CLINIC OF UAB HOSPITAL

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date of Service: _____
Physician: _____

MEMORY DISORDERS CLINIC AUTHORIZATION TO SHARE MEDICAL INFORMATION **continued page 2**

Specific description of information:

X	Face Sheet	X	Discharge Summary
X	History and Physical	X	Pathology Report
X	Emergency Room Record	X	Diagnostic Procedure Report(s)
X	Lab Report(s)	X	Problem List
X	Medication List	X	X-ray Report(s)
X	Clinic Notes	X	Operative Report(s)
X	Radiology Films	X	Billing Records
X	Other (please describe):	prescription refills, problems, and concerns related to my medical care	

Purpose of Use or Disclosure:

This information for which I am authorizing disclosure will be used for the following purpose:

_____	My personal records	X	Other (please describe): to facilitate and expedite my care.
X	Sharing PHI with those responsible for my care as listed above.		

The patient or the patient's representative must read and initial the following statements: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity privacy coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ Initial: I understand that I may revoke this Authorization at any time by notifying the UABHS Privacy Officer in writing, but if I do, it will not have any effect to the extent UABHS took action in reliance on the Authorization.

_____ Initial: I understand that UABHS may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

- Participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research.
- Initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations.
- Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.

This authorization will expire (Date of event): **Until revoked.**

Signature of Patient or Patient's Representative: _____

Printed Name of Patient: _____

Printed Name of Patient's Representative: _____

Relationship to the Patient: _____

Date: _____

UAB MEDICINE
THE KIRKLIN CLINIC OF UAB HOSPITAL

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date of Service: _____
Physician: _____

MEDICATIONS and ALLERGIES

Prescription Medication- Patient is Taking Now			
Name	**Strength (mg,**	**Dosage?**	**How often?**

Over The Counter Medication - Patient is Taking Now			
Name	**Strength (mg,**	**Dosage?**	**How often?**

Vitamins, Herbal Supplements and Other - Patient is Taking Now			
Name	**Strength (mg, mcg, units, etc.)**	**Dosage?**	**How often?**

MEDICINE ALLERGIES

Has the patient had an allergic reaction to any medicine? If yes, list them below	
Medicine Name	**Allergic Reaction**