erlanger

UT Erlanger Neurology Memory and Aging Service Questionnaire

FOLLOW-UP PATIENTS: Please fill out the following as completely as possible.

Patient's Name_____ Date of birth _____

Primary Care Physician _____ Preferred Pharmacy/Phone# _____

Please describe the reason for today's visit:

Please list you drug allergies and the reaction (*Example: Penicillin – rash*):

Are you allergic to latex? **Yes / No** Are there any food allergies? **Yes / No**

Please list **all** of you current medications, dosage, frequency, and the reason for taking them. Please include all **over-the counter** medications **and as-needed** medications that have been taken **in the last 2 weeks**. Please include all vitamins and herbal medications as well. If you run out of space, use the back of this page. *(Example: Aspirin 325mg once daily for stroke; ibuprofen 200mg as needed for headaches; vitamin D3 400IU once daily for low vit D level; fish oil 1000mg for general health)*

Medication	**Dose**	**Frequency**	**Reason for taking**

Since you last visit to the Memory and Aging Service at UT Erlanger Neurology (If you answer yes to any of the following questions, please provide the date and any details you recall):

Have there been any emergency room and/ or hospital or inpatient rehab visits? **Yes / No**

New surgeries or procedures? **Yes / No**

Falls or injuries? **Yes / No**

New medical diagnoses from your other doctors? **Yes / No**

Changes to your family's medical history? **Yes /** No

Are you currently smoking? **Yes / No**

Any current alcohol use? **Yes/ No**
How many alcohol beverages (beer, wine, liquor, mixed drinks) per week? _____

Have you recently used any illegal substances (including marijuana)? **Yes / No**

Any current coffee/tea/caffeinated beverage use? **Yes / No** How many beverages daily on average? _____

Any changes in your living situation? (Examples – recently moved, illness or death of another member of the household, etc)

Yes / No – if yes, please explain:

If there is a **problem with walking or frequent falls**, please answer the following questions:

Do you associate the problem with pain? **Yes / No** Do you associate the problem with weakness? **Yes / No**
Do you associate the problem with dizziness? **Yes / No** Vertigo? **Yes / No** Lightheadedness? **Yes / No**
How many falls in the last month? _____
Can you identify a reason for your falls, such as uneven ground, rugs, tripping on your own feet, etc?

If there is a **problem with dizziness**, please provide further details:

Geriatric Depression Scale

To be filled out by patients with memory problems or problems with depression/anxiety

This form should not be filled out by family, though family may assist.

Instructions to the patient: Please circle the answer that best describes how you have felt over **the last week.** You must choose the best answer, yes or no. **Do not skip any questions.**

1. **Yes** **No** Are you basically satisfied with your life?
2. **Yes** **No** Have you dropped many of your activities and interests?
3. **Yes** **No** Do you feel that your life is empty?
4. **Yes** **No** Do you often get bored?
5. **Yes** **No** Are you in good spirits most of the time?
6. **Yes** **No** Are you afraid that something bad is going to happen to you?
7. **Yes** **No** Do you feel happy most of the time?
8. **Yes** **No** Do you feel helpless?
9. **Yes** **No** Do you prefer to stay at home, rather than going out and trying new things?
10. **Yes** **No** Do you feel that you have more problems with memory than most?
11. **Yes** **No** Do you think it is wonderful to be alive now?
12. **Yes** **No** Do you feel worthless the way you are now?
13. **Yes** **No** Do you feel full of energy?
14. **Yes** **No** Do you feel that your situation is hopeless?
15. **Yes** **No** Do you think that most people are better off than you are?

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Completed by (check one):

- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

erlanger

Functional Activities Questionnaire

Caregiver, please rate the patient's ability using the following scoring system:

- Dependent = 3
- Requires Assistance = 2
- Has difficulty but does by self = 1
- Normal = 0
- Never did [the activity] but could do now = 0
- Never did and would have difficulty now = 1

1. writing checks, paying bills, balancing checkbook	
2. Assembling tax records, business affairs, or papers	
3. Shopping alone for clothes, household necessities, or groceries	
4. Playing a game of skill, working on a hobby	
5. Heating water, making a cup of coffee, turning off stove after use	
6. Preparing a balanced meal	
7. Keeping track of current events	
8. Paying attention to, understanding, discussing TV, book, magazine	
9. Remembering appointments, family occasions, holidays, medications	
10. Traveling out of neighborhood, driving, arranging to take buses	
TOTAL SCORE:	

Pfeffer, R.I., Kurosaki, T.T., Harrah, C.H. Jr., Chance, J.M., & Filos, S. (1982). Measurement of functional activities in older adults in the community. Journal of Gerontology, 37(3), 323-329. Reprinted with permission of Oxford University Press

Behav5+ (@ s. Borson, T. Sadak) To be filled out by caregiver/ family member

Please check yes for the behaviors that **you have observed** in your care recipient **in the past month.**

1. **Agitation** Does your care recipient get angry or hostile? Resist care from others? Yes/ No
2. **Hallucinations**
   Does your care recipient see and/ or hear things that no one else can see or hear? Yes/ No
3. **Irritability/ Frequently changing mood** Does your care recipient act impatient and cranky? Does his or her mood frequently change for no apparent reason? Yes/No
4. **Suspiciousness/ Paranoia**
   Does your care recipient act suspicious without good reason? (example: believes that others are stealing from them, or planning to harm them in some way?) Yes/ No
5. **Indifference/ Social Withdrawal**
   Does your care recipient seem less interested in his/ her usual activities and plans of others? Yes/ No

6. **Sleep Problems** Does our care recipient have trouble sleeping at night? Yes/ No

Being a **caregiver** for a loved one with a memory disorder can be very difficult. Caregivers are at increased risk of serious illness (including circulatory and heart conditions and respiratory disease and hypertension), increased physician visits and use of prescription medications, emotional strain, anxiety, and depression. If you are a caregiver, please tell us about your stress level by completing the following assessment:

As a caregiver, both the patient and the patient's doctors depend on you to take care of yourself! You cannot take care of others if you do not take care of yourself. Regular exercise and a balanced diet are key to maintaining your own health. Please be sure to discuss your medical and mental health concerns with your own doctor.

Zarit Caregiver Burden Assessment. The following is a list of statements that reflect how people sometimes feel when taking care of another person. After reading each statement, indicate how often you experience the feelings listed by circling the number that best corresponds to the frequency of these feelings.

	Never	Rarely	Sometimes	Frequently	Nearly Always
1) Do you feel you don't have enough time for yourself?	0	1	2	3	4
2) Do you feel stressed between caring and meeting other responsibilities?	0	1	2	3	4
3) Do you feel angry when you are around your relative?	0	1	2	3	4
4)Do you feel your relative affects your relationship with others in a negative way?	0	1	2	3	4
5) Do you feel strained when you are around your relative?	0	1	2	3	4
6) Do you feel your health has suffered because of your involvement with your relative?	0	1	2	3	4
7) Do you feel you don't have as much privacy as you would like, because of your relative?	0	1	2	3	4
8) Do you feel your social life has suffered because you are caring for your relative?	0	1	2	3	4
9) Do you feel you have lost control of your life since your relative's illness?	0	1	2	3	4
10) Do you feel uncertain about what to do about your relative?	0	1	2	3	4
11) Do you feel you should be doing more for your relative?	0	1	2	3	4
12) Do you feel you could do a better job at caring for your relative?	0	1	2	3	4

Scoring Instructions: Add Items 1-12 Total 1-12 (maximum score = 48) _____

Michel Bédard, PhD,1,2 D. William Molloy, MB,3 Larry Squire, MA,1 Sacha Dubois, BA,3 Judith A. Lever, MSc(A),4 and Martin O'Donnell, MRCP(I)3 The Gerontological Society of America Vol. 41, No. 5, 652–657 The Gerontologist the Zarit Burden Interview: A New Short Version and Screening Version

Thank you for filling out this questionnaire.

Recommendations for your upcoming visit to the Memory and Aging Service at Erlanger Neurology:

1) Wear well-fitting, comfortable, flat/level shoes. Do not wear bedroom slippers, flip-flops, or anything with a high heel.

2) Bring glasses and hearing aids.

3) Bring any devices that are used for walking around your home, such as walkers or canes.

4) Bring a complete and accurate list of medications, including any vitamins, supplements, and over-the-counter meds.

5) Be sure to turn off or silence any cell phones, especially during the memory testing, to avoid distractions.

6) ***If your appointment is scheduled at the Erlanger North location***, please note that the bathrooms are located outside of our actual office. Please stop there before making it all the way to our office if needed.

For office use only:

Pain Assessment – Severity: Mild Moderate Severe

N/A

0 1 2 3 4 5 6 7 8 9 10

Location:

Vitals: BP

Pulse

Notes to MD:

erlanger

UT Erlanger Neurology

Erlanger Southeast Regional Stroke Center

Name: _____ **DOB:** _____

It is the policy of this office to keep all medical records confidential. There may be occasions when you need this information released to another office/person. Please answer the following questions and authorize us to give your confidential information in these situations:

1. May we leave your medical information, including test results, on an answering machine, or give it to another person, such as a spouse, adult child or caregiver? YES _____ NO _____

Name / Relationship: _____ **Phone #** _____

Name / Relationship: _____ **Phone #** _____

2. May we give pertinent information to your primary care doctor, the doctor who referred you here, or a doctor we refer you to? YES _____ NO _____

3. May we leave detailed appointment reminders or messages to call us back on your answering machine at home, work, or cell phone, or with whoever answers the phone? YES _____ NO _____

4. May we share your contact information (name and telephone number) with project coordinators, if you may be interested in participating in research? YES _____ NO _____

Patient Signature _____ **Date** _____