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 your 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 daily 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 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:

Review of Systems: Please circle if you have any of these symptoms related to the reason for **today's visit**. You can also circle a symptom if you have had it in the last **2 weeks** for any reason. **Please check NONE if none of the symptoms are present.**

General - ☐ NONE Fever Unintentional weight loss Unintentional weight gain Change in appetite Change in activity Fatigue/Low energy	**Neurologic - ☐ NONE** Headaches Change in balance Falls Dizziness Lightheadedness Fainting/lost consciousness Weakness on one side Numbness on one side Other weakness Other numbness/tingling Facial droop Tremors Seizures Memory loss Language/speech changes	**Behavior/Psychiatric/Sleep - ☐ NONE** Depression/sadness Personality change Loss of interest in hobbies Decreased concentration Fearfulness/Anxiety Crying spells Inappropriate laughing Anger/Irritability Agitation Hallucinations Delusions Wandering Thoughts of suicide Self-injury behavior Sleep/wake cycle changes Acting out dreams Daytime sleepiness	**Head/Ears/Eyes/Nose/Throat - ☐ NONE** Problems swallowing Dry mouth Drooling Slurred speech Loss of voice volume Change in sense of smell Hearing loss / Hearing Aids Ringing in ears/Tinnitus Sensitivity to sound Sinus pressure Sensitivity to light Complete vision loss Double vision Blurred vision If blurry - is vision better with glasses? **Yes / No**
Musculoskeletal - ☐ NONE Joint pain/stiffness Joint swelling Muscle pain Back pain Neck pain Neck stiffness Difficulty walking due to pain	**Gastrointestinal - ☐ NONE** Abdominal pain Reflux/Heartburn Constipation Diarrhea Nausea/Vomiting Bowel incontinence	**Genitourinary - ☐ NONE** Urinary frequency Urinary urgency Bladder incontinence Pain with urination Blood in urine Frequent urinary tract infections Difficulty emptying bladder	**Cardiovascular - ☐ NONE** Chest pain Palpitations Lower extremity swelling Low blood pressure High blood pressure that is difficult to control Low pulse rate High pulse rate
Respiratory - ☐ NONE Shortness of breath Cough Wheezing Loud snoring in sleep Stop breathing in sleep	**Dermatological - ☐ NONE** Rash Skin ulcers/wound	**Hematological - ☐ NONE** Easy bruising Easy bleeding Abnormal clotting Low immunity	**Endocrine - ☐ NONE** Intolerance of heat or cold Low blood sugars

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 <u>patients</u> 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 **<u>the</u> <u>last</u> <u>week</u>**. 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 often 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?

<u>For office use only:</u>

Pain Assessment – Severity: Mild Moderate Severe

N/A 0 1 2 3 4 5 6 7 8 9 10

Location:

Vitals: BP Pulse Weight Height BMI Temp

Notes to MD:

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

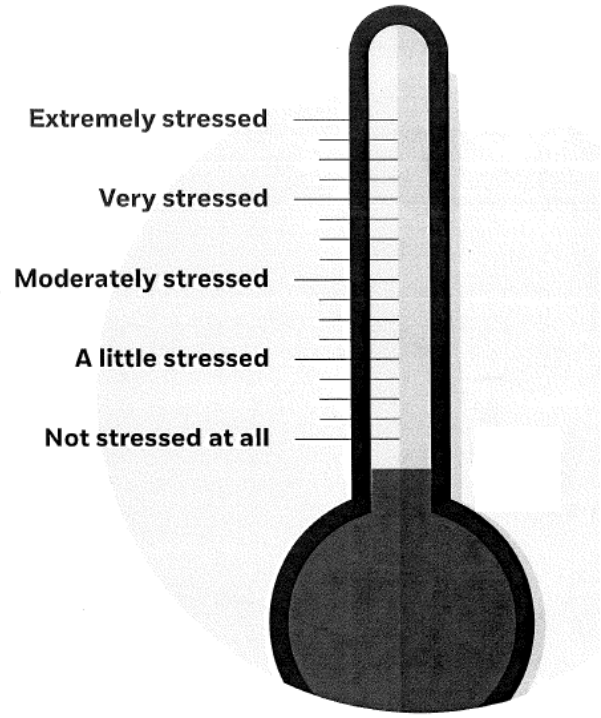
Please circle the number that best describes how you feel NOW:

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

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 indicate your stress level on the **Stress Thermometer** below.

*STRESS: Feeling tense, nervous, anxious, restless, or unable to sleep because your mind is troubled all the time.**



©S. Borson | *Reference: Elo A-L, Leppänen A, Jahkola A. Scand J Work Environ Health 2003;29(6):444–451.

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.

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.

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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_____**

Patient Signature_____ **Date** _____