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

Name: ______________________ DOB: ______________

Which hand do you write with? Right / Left / Both Who referred you to our clinic? ______________

Primary Care Physician: ______________________ Phone #: ______________

Preferred Pharmacy: ______________________ Phone #: ______________

Please describe the reason for today's visit: ______________________

Please list your drug allergies and the reaction (*example: Penicillin - rash*): ______________________

Are you allergic to latex? YES _____ NO _____ Do you have any food allergies? YES _____ NO _____ *if yes, please list:* ______________

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 vitamin D level; fish oil 1000mg daily for general health.*

Medication	Dose	Frequency	Reason for taking

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PERSONAL HISTORY

Since your last visit to Erlanger Neurology, have you had any of the following?

Emergency room visits? **Yes / No** If yes, please provide the date and any details you recall: ______________________________

New surgeries or procedures? **Yes / No** If yes, please provide the date and any details you recall: ______________________________

Falls or injuries? **Yes / No** If yes, please provide the date and any details you recall: ______________________________

New medical diagnoses from your other doctors? **Yes / No** If yes, please provide the date and any details you recall: ______________________________

Changes to your family's medical history? **Yes / No** If yes, please provide the date and any details you recall: ______________________________

Are you currently smoker? **Yes / No** Average packs per day: ____________ How many years? ____________

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

Is there a history (past or present) of any illegal substance (including marijuana) use? **Yes / No**

Any current coffee/tea/caffeinated beverage use? **Yes / No** If yes, how many beverages daily on average? ____________

Any changes in your living situation? (Examples: recently moved, illness or death of a member of the household, etc.) **Yes / No**

____

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: ____________________

Review of systems: Please check 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
- ❑ Fever
- ❑ Unintentional weight loss
- ❑ Unintentional weight gain
- ❑ Change in appetite
- ❑ Change in activity
- ❑ Fatigue/Low energy
- ❑ None

Neurologic
- ❑ 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
- ❑ None

Behavior/Psychiatric/Sleep
- ❑ 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
- ❑ None

Head/Ears/Eyes/Nose/Throat
- ❑ 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**
- ❑ None

Musculoskeletal
- ❑ Joint pain/stiffness
- ❑ Joint swelling
- ❑ Muscle pain
- ❑ Back pain
- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Difficulty walking due to pain
- ❑ None

Gastrointestinal
- ❑ Abdominal pain
- ❑ Reflux/heartburn
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea/vomiting
- ❑ Bowel incontinence
- ❑ None

Genitourinary
- ❑ Urinary frequency
- ❑ Urinary urgency
- ❑ Bladder incontinence
- ❑ Pain with urination
- ❑ Blood in urine
- ❑ Frequent urinary tract
- ❑ Infections
- ❑ Difficulty emptying bladder
- ❑ None

Cardiovascular
- ❑ Chest pain
- ❑ Palpitations
- ❑ Lower extremity swelling
- ❑ Low blood pressure
- ❑ High blood pressure that is
- ❑ Difficult to control
- ❑ Low pulse rate
- ❑ High pulse rate
- ❑ None

Respiratory
- ❑ Shortness of breath
- ❑ Cough
- ❑ Wheezing
- ❑ Loud snoring in sleep
- ❑ Stop breathing in sleep
- ❑ None

Dermatological
- ❑ Rash
- ❑ Skin ulcers/wound
- ❑ None

Hematological
- ❑ Easy bruising
- ❑ Easy bleeding
- ❑ Abnormal clotting
- ❑ Low immunity
- ❑ None

Endocrine
- ❑ Intolerance of heat or cold
- ❑ Low blood sugars
- ❑ None

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: ____

____

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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 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: ____________________

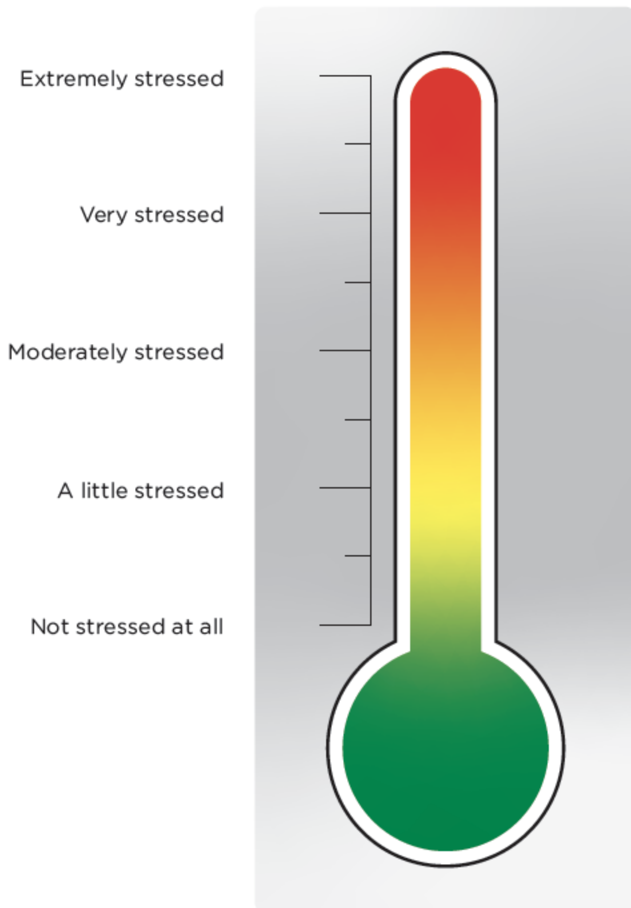
Vitals: ________ BP ________ Pulse ________ Weight ________ Height ________ BMI ________ Temp.

Notes to MD: ____________________

____

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, 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.



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.

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

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

Thank you for filling out this questionnaire.