erlanger

UT Erlanger Neurology
Erlanger Southeast Regional Stroke Center

979 East Third Street
Medical Mall, Suite C-830
Chattanooga, TN 37403
423 778-9001

Thank you for choosing UT Erlanger Neurology for your healthcare needs. Our office received a request for an appointment for you to get established with our practice. Enclosed, please find a Patient Information form and Medical History form.
Please complete these forms and bring them with you to your appointment.

> Please bring **all medications** (including any over the counter medications or herbal supplements), **insurance cards** and **photo ID** to your appointment. Your co-pay is due at the time of visit. If you do not have insurance, please contact our office to discuss payment.

DUE TO THE LARGE AMOUNT OF PATIENTS ON OUR WAITING LIST, **IF YOU NEED TO RESCHEDULE, PLEASE CALL 48 HOURS PRIOR TO YOUR APPOINTMENT.** ALL **"NO SHOW"** APPOINTMENTS WILL BE SUBJECT TO A $25.00 NO SHOW CHARGE AND/OR DENIAL OF FUTURE VISITS.

Appointment requested by: _____

Scheduled with _____Dr. Berneet Kaur_____

On: _____at _____a.m. p.m.___

Thank you in advance for completing these forms and we look forward to meeting you in the near future.

Sincerely,
UT Erlanger Neurology/Southeast Regional Stroke Center

Directions to our office from the Medical Mall parking garage:
Walk across the bridge on the 1st floor of the garage toward the Medical Mall
At the end of the bridge you will see CVS Pharmacy on your left
Take the "C" Elevator to the 8th floor (Suite C-830)

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PATIENT

Name_____Age_____DOB_____SS #_____

Address_____City/State/Zip_____

Phone Numbers: Home (____)_____ Cell (_____)_____ Work (_____)_____

Employer_____Occupation_____

Please circle: Male / Female **RACE:** _____ **Please Circle**: Single / Married / Widowed / Divorced

SPOUSE / GUARDIAN

Name_____Age_____DOB_____SS #_____

Address_____City/State/Zip_____

Phone Numbers: Home (____)_____ Cell (_____)_____ Work (_____)_____

Employer_____Occupation_____

EMERGENCY CONTACT

Name _____Phone (____)_____ Relation _____

INSURANCE

PRIMARY INSURANCE _____ **Group #**_____ **ID #**_____

Insured's Name_____ DOB_____ SS #_____

SECONDARY INSURANCE _____ **Group #**_____ **ID #**_____

Insured's Name_____ DOB_____ SS #_____

Primary Care Physician_____ **Phone (_____)**_____

Referred By_____ **Phone (_____)**_____

PHARMACY

Name_____ Phone (_____)_____

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** _____

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UT Erlanger Neurology Memory and Aging Service Questionnaire

NEW PATIENTS: Please fill out the following as completely as possible.

Patient's Name _____ Date of birth _____

Which hand do you write with? **Right** **Left** **Both** Who referred you to our clinic? _____

Primary Care Physician _____ Preferred Pharmacy/Phone# _____

Race/Ethnicity _____ Gender _____

How far did you go in school?

None	Elementary								High School				College/Vocational				Graduate			
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

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** Are there 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 vit D level; fish oil 1000mg daily for general health)*

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

Patient's Name _____Date of birth _____

Here is a list of medications that can affect the way the brain and neurological system work (in both good and bad ways). Please circle all medications that you have taken for **any reason in the past**, even if you are no longer taking it. If you had a side-effect to the medication, please list it to the right of the medication name. If you have **never** taken any of these medications, check **NONE** ☐

Cognitive Enhancers
Aricept/donepezil
Razadyne/galantamine
Exelon/rivastigmine
Namenda/memantine
Namzaric/memantine+donepezil

Seizure Medications
Depakote/valproate/divalproex
Dilantin/phenytoin
Gabatril/tiagabine
Lyrica/pregabalin
Keppra/levetiracetam
Vimpat/lacosamide
Lamictal/lamotrigine
Neurontin/Gralise/gabapentin
Tegretol/carbamazepine
Trileptal/oxcarbazepine
Aptiom/eslicarbazepine
Zonegran/zonisamide
Topamax/Trokendi/topiramate
Fycompa/perampanel
Phenobarbital or Primidone

Antidepressants
Elavil/amitriptyline
Pamelor/nortriptyline
Sinequan/doxepin
Celexa/citalopram
Lexapro/escitalopram
Prozac/Serefem/fluoxetine
Zoloft/sertraline
Paxil/Pexeva/paroxetine
Luvox/fluvoxamine
Brintellix/vortioxetine
Cymbalta/duloxetine
Savella/milnacipran
Effexor/venlafaxine
Pristiq/desvenlafaxine
Wellbutrin/bupropion
Desyrel/trazaodone
Remeron/mirtazapine
Buspar/buspirone
Symbyax/fluoxetine + olanzapine

Other psychiatric medications
Nudexta/dextromethorphan+quinidine
Nuplazid/pimvanserin
Seroquel/quetiapine
Risperidal/risperidone
Clozaril/clozapine
Zyprexa/olanzapine
Geodon/ziprasidone
Rexulti/brexipiprazole
Abilify/aripiprazole
Vraylar/cariprazine
Haldol/haloperidol
Thorazine/chlorpromazine
Orap/pimozide or Navane/thiotixene
Loxitane/loxapine
Lutada/lurasidone
Inveg /paliperidone
Prolixin / fluphenazine

Blood thinners/Anti-platelets
Aspirin or Plavix/clopidogrel or Effient/prasugrel
Aggrenox/aspirin+dipyridamole
Coumadin/Jantoven/warfarin
Pradaxa/dabigatran
Eliquis/apixaban
Xarelto/rivaroxaban

Stimulants
Amphetamines (multiple names) – Ritalin/ Concerta/Adderall/Dexedrine/Vyvanse/Focalin
Provigil/modafinil
Nuvigil/armodafinil

Nutriceuticals
Axona/caprylic acid
Vitamin B1/thiamine
Vitamin B2/riboflavin
Vitamin B12
Vitamin C Vitamin D Vitamin E
Folate
Fish oil/Omega 3
Gingko Biloba
Co-enzyme Q10
Choline or phosphatidylcholine
Phosphatidylserine
Focus Factor
Huperzine A
SAM-e/S-adenosyl-L-methionine
Cerefolin NAC
Vayacog/phosphatidylserine+DHA+EPA
Coconut oil
Tramiprosate

Sedatives/benzodiazepines
Ativan/lorazepam
Klonopin/clonazepam
Restoril/temazepam
Tranxene/clorazepate
Valium/diazepam
Xanax/alprazolam
Librium/chlordiazepoxide

Antihistamines/allergy medications
Allegra/fexofenadine
Claritin/loratadine
Clarinex/desloratadine
Zyrtec/cetirizine
Atarax/hydroxyzine
Benadryl/diphenhydramine

Bladder/prostate medications
Detrol/tolterodine
Ditropan/oxybutynin
Sanctura/trospium
Vesicare/solefenacin
Enablex/darifenacin
Myrbetriq/mirabegron
Toviaz/fesoterodine
Flomax/tamsulosin
Hytrin/terazosin
Cardura/doxazosin
Minipress/prazosin
Uroxatral/alfuzosin

Sleep Aids
Ambien/zolpidem
Lunesta/eszopiclone
Sonata/zaleplon
Rozerem/ramelteon
Belsomra/suvorexant
melatonin
Tylenol PM or Advil PM or Aleve PM or Nyquil
Simply Sleep/diphenhydramine
Unisom/doxylamine

Anti-vertigo/anti-dizziness medications
Dramamine/Gravol/dimenhydrinate
Dramamine24hr/Antivert/meclizine

Headache Medications
Amerge/naratriptan
Axert/almotriptan
Frova/frovatriptan
Imitrex/sumatriptan
Maxalt/rizatriptan
Relpax/eletriptan
Zomig/zolmitriptan
Treximet/sumatriptan+naproxen
Migranal/dihydroergotamine
Excedrin
Fioricet/butalbital+acetaminophen+caffeine
Fiorinal/butalbital+aspirin+caffeine
Goody powders
Midrin/dicloralphenazone+isometheptene+acetam

Anti-nausea/GI medications
Compazine/prochlorperazine
Reglan/metoclopramide
Phenergan/promethazine
Tigan/trimethabenzamide
Zofran/ondansetron

Muscle Relaxants
Flexaril/cyclobanzprine
Liorisol/baclofen
Robaxin/methocarbamol
Skelaxin/metaxalone
Soma/carisoprodol
Zanaflex/tizanidine

Steroids/Anti-inflammatory
Decadron/dexamethasone
Medrol/solumedrol
Prednisone
Celebrex/celecoxib
Indocin/indomethacin
Mobic/meloxicam
Motrin/Advil/ibuprofen
Naprosyn/Aleve/naproxen
Relafen/nambumetone
Toradol/ketorolac
Voltaren/Cambia/Zipsor/diclofenac

Narcotics/Opiates
Duragesic/fentanyl
Darvon/Darvocet/propoxyphene
Demerol/meperidine
Dilaudid/hydromorphone
Methadone
Percocet/Oxycontin/oxycodone
Vicodin/Norco/hydrocodone
Stadol/butorphanol or Ultram/tramadol

Blood Pressure Medications
Calan/verapamil
Norvasc/amlodipine
Procardia/nifedipine
Corgard/nadolol
Inderal/propranolol
Lopressor/metoprolol
Tenormin/atenolol
Trandate/labetolol
Cardura/doxazosin
Minipress/prazosin

Parkinson's and Restless Legs Medications
Carbidopa/levodopa/combo (multiple names) - Sinemet/Stalevo/Parcopa/Rytary
Mirapex/pramipexole
Requip/ropinirole

Patient's Name _____Date of birth _____

Medical History: Circle if you currently have the following problems **OR** have had them in the past.

Stroke / Ministroke / TIA	Seizure / Convulsion / Epilepsy	Traumatic brain injury / Concussion
Brain / spinal infection	Sexually transmitted / venereal disease	Any vitamin / iron deficiency
Thyroid problems	Osteoporosis / Osteopenia	Depression / Anxiety
Kidney stones	Stomach / GI ulcer	GI / stomach / rectal bleeding
Cancer	Cancer chemotherapy	Cancer radiation therapy
Anemia / Low blood counts	Bleeding / Clotting disorder	Blood transfusion
Alcoholism / heavy alcohol use	Chemical exposures	History of contact sports (tackle football, boxing, etc)
Frequent bladder infections / UTIs	Enlarged prostate	Atrial fibrillation
Hypertension / High blood pressure	Diabetes / Prediabetes	Cholesterol / Triglyceride problems
Macular degeneration	Lupus / Rheumatoid arthritis	Other rheumatological disease

Please list any other medical problems that you currently have or previously had.

Are you on dialysis or have any kidney disease? Y/N

Surgical History: Circle if you have had any of the following surgeries and include the month/year:

Pacemaker / defibrillator placement	Cataract surgery	Other eye / retinal procedures
Heart Bypass / CABG	Heart stents / Angioplasty	Carotid artery surgery
Cervical spine / Neck surgery	Lower back / Lumbar surgery	Spinal injections
Hip surgery / replacement	Knee surgery / replacement	Other stimulator placement
Tonsillectomy / Adenoidectomy	Appendectomy	Other bone fractures?
Cholecystectomy / Gall bladder	Hernia surgery	Hysterectomy

Please list any other surgeries you have had. Be sure to include any metallic surgical implants. If you can, please bring the implant/device information for your chart, in case you need an MRI.

Is there a history of psychiatric hospitalization? Yes / No If yes, please list month/year of hospitalization.

Please list any other hospitalizations you have had not included above. Include the reason for hospitalization and the month/year.

Patient's Name _____Date of birth _____

Family history:

	Father	Mother	Sibling	Children	Grandparents	Aunt/Uncle	Cousins
Heart disease							
High blood pressure							
Diabetes							
Cancer							
Bleeding/Clotting disorders							
Lupus/Rheumatoid disorders							
Epilepsy/Seizure							
Stroke/Ministrokes/TIAs							
Headaches/Migraines							
Multiple Sclerosis							
Parkinson's disease							
Tremors							
Dementia/Alzheimer's/Memory changes							
Mental Illness/Psychiatric hospitalization							

Personal history:

Birthplace_____ What is the patient's first language? _____

If born outside of the US, how old was the patient when he/she moved to the US? _____

Marital status (Circle) Single / Married / Partnered / Widowed / Divorced How many years? _____

What is/was the patient's occupation? _____

Is the patient a veteran? **Yes / No**

Who lives in the home with the patient? _____

Can the patient live alone safely? **Yes / No** Does the patient live in a facility? **Yes / No**

Is the patient driving? **Yes / No** Does he/she have a valid driver's license **Yes / No**

Are there any weapons in the home? **Yes / No**

Has the patient smoked over 100 cigarettes in his/her lifetime? **Yes / No** If yes, current smoker? **Yes / No**

Average packs per day _____ How many years? _____ When did you quit? _____

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

Is there a history of heavy alcohol use? **Yes / No**

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

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

Does the patient have any advanced directives or a living will? **Yes / No**

Patient's Name _____Date of birth _____

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?

Patient's Name _____Date of birth _____

If there is a **problem with memory**, please make sure to bring a family member or trusted friend with you to the appointment. Please have that **friend or family member** answer the next few pages, based on his/her interactions with you. This form is to be filled out by family or friends only, not the patient.

Name of person filling out this page and relationship to the patient: _____

Are there any other symptoms related to the memory loss which the patient or their loved ones have noticed and would like to discuss?

Answer yes **only** if the problem is due to memory loss, not physical issues:

1. Does the patient often repeat him/herself or ask the same questions over and over? **Yes / No / Don't Know**
2. Does the patient forget what ***month or year*** it is? **Yes / No / Don't Know**
3. Does the patient *frequently* have trouble finding the words he/she wants to say, finishing sentences, or naming people or things? **Yes / No / Don't Know**
4. Is the patient more forgetful, that is, having trouble with short-term memory, on a ***daily*** basis? **Yes / No / Don't Know**
5. Does the patient forget appointments, family occasions, or holidays? **Yes / No / Don't Know**
6. Does the patient need reminders to do things like chores or shopping? **Yes / No / Don't Know**
7. Does the patient need reminders or other supervision to take medicines? **Yes / No / Don't Know**
8. Does the patient have more trouble than usual using gadgets, like the TV remote or home telephone? **Yes / No / Don't Know**
9. Has the patient shown poor judgment, for instance, difficulty making decisions or given money or information to someone inappropriately? **Yes / No / Don't Know**
10. Has the patient started having trouble doing calculations, managing finances, or balancing the checkbook? If the patient has never managed finances or the checkbook, answer "N/A". **Yes / No / Don't Know / N/A**
11. Are there concerns about the patient driving, for example, getting lost or driving unsafely, or has the person had to stop driving? If the patient has never driven, answer "N/A". **Yes / No / Don't Know / N/A**
12. Does the patient need help eating, dressing, bathing, or using the bathroom? **Yes / No / Don't Know**
13. Does the patient seem sad, down in the dumps, or cry more often than in the past? **Yes / No / Don't Know**
14. Has the patient become irritable, agitated, suspicious, or started seeing, hearing, or believing things that are not real? **Yes / No / Don't Know**

Patient's Name _____Date of birth _____

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:	

Sum score 0-30
Cut-point of 9 (dependent in 3 or more activities) is recommended to indicate impaired function/ cognitive impairment

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

Patient's Name _____Date of birth _____

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

Patient's Name _____Date of birth _____

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 You are scheduled at the Erlanger North Campus, please know that the bathrooms are located outside of the actual office. Please stop there before making it all the way to our office if you need to.

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 Weight Height BMI Temp

Notes to MD: