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________

Patient Signature____ **Date** __________________

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

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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/r boflavin
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/celecox b
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 ______________

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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	**Neurologic - ☐ NONE**	**Behavior/Psychiatric/Sleep - ☐ NONE**	**Head/Ears/Eyes/Nose/Throat - ☐ NONE**
Fever Unintentional weight loss Unintentional weight gain Change in appetite Change in activity Fatigue/Low energy	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	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	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:

Patient's Name ________________________________ Date of birth ____________________

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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?

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:

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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 ________________________

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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 guns 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 ______________________

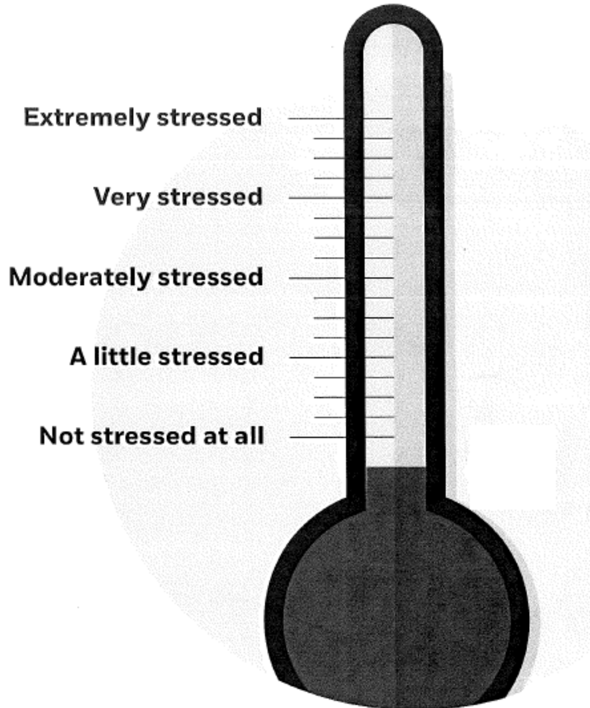
If there is a **problem with memory**, please make sure to bring a family member or trusted friend with you to the appointment. Please have that **friend or family member** answer the following questions, based on his/her interactions with you. This form is to be filled out by family or friends only,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

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?

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.



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.