Memory & Aging Service Questionnaire
New Patient

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PATIENT

Name: _____ Age: _____ DOB: _____ SS #: _____

Address: _____ City/State/Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Occupation: _____

Race: _____ Please circle: Male / Female & Single / Married / Partnered / Widowed / Divorced

SPOUSE/GUARDIAN

Name: _____ Age: _____ DOB: _____ SS#: _____

Address: _____ City/State/Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____ Relation: _____

INSURANCE

Primary Insurance: _____ Group #: _____ ID #: _____

Insured Name: _____ DOB: _____ SS #: _____

Secondary Insurance: _____ Group #: _____ ID #: _____

Insured Name: _____ DOB: _____ SS #: _____

Primary Care Physician: _____ Phone #: _____

Referred By: _____ Phone #: _____

PHARMACY

Primary Care Physician: _____ 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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NEW 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 #: _____

Highest Level of Education: _____ Race: _____ Please circle: Male / Female

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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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, circle **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
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 or Vitamin D or 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/allery 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
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

Nacrcotics/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 & restless legs medications
Carbidopa/levodopa/combo (multiple names) Sinemet/Stalevo/Parcopa/Rytary
Mirapex/pramipexole
Requip/ropinirole

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	**Neurologic**	**Behavior/Psychiatric/Sleep**	**Head/Ears/Eyes/Nose/Throat**
❑ Fever	❑ Headaches	❑ Depression/sadness	❑ Problems swallowing
❑ Unintentional weight loss	❑ Change in balance	❑ Personality change	❑ Dry mouth
❑ Unintentional weight gain	❑ Falls	❑ Loss of interest in hobbies	❑ Drooling
❑ Change in appetite	❑ Dizziness	❑ Decreased concentration	❑ Slurred speech
❑ Change in activity	❑ Lightheadedness	❑ Fearfulness/anxiety	❑ Loss of voice volume
❑ Fatigue/Low energy	❑ Fainting/lost consciousness	❑ Crying spells	❑ Change in sense of smell
❑ None	❑ Weakness on one side	❑ Inappropriate laughing	❑ Hearing loss/hearing aids
	❑ Numbness on one side	❑ Anger/irritability	❑ Ringing in ears/tinnitus
	❑ Other weakness	❑ Agitation	❑ Sensitivity to sound
	❑ Other numbness/tingling	❑ Hallucinations	❑ Sinus pressure
	❑ Facial droop	❑ Delusions	❑ Sensitivity to light
	❑ Tremors	❑ Wandering	❑ Complete vision loss
	❑ Seizures	❑ Thoughts of suicide	❑ Double vision
	❑ Memory loss	❑ Self-injury behavior	❑ Blurred vision If blurry, is vision better with glasses? **Yes / No**
	❑ Language/speech changes	❑ Sleep/wake cycle changes	❑ None
	❑ None	❑ Acting out dreams	
		❑ Daytime sleepiness	
		❑ None	

Musculoskeletal	**Gastrointestinal**	**Genitourinary**	**Cardiovascular**
❑ Joint pain/stiffness	❑ Abdominal pain	❑ Urinary frequency	❑ Chest pain
❑ Joint swelling	❑ Reflux/heartburn	❑ Urinary urgency	❑ Palpitations
❑ Muscle pain	❑ Constipation	❑ Bladder incontinence	❑ Lower extremity swelling
❑ Back pain	❑ Diarrhea	❑ Pain with urination	❑ Low blood pressure
❑ Neck pain	❑ Nausea/vomiting	❑ Blood in urine	❑ High blood pressure that is
❑ Neck stiffness	❑ Bowel incontinence	❑ Frequent urinary tract	❑ Difficult to control
❑ Difficulty walking due to pain	❑ None	❑ Infections	❑ Low pulse rate
❑ None		❑ Difficulty emptying bladder	❑ High pulse rate
		❑ None	❑ None

Respiratory	**Dermatological**	**Hematological**	**Endocrine**
❑ Shortness of breath	❑ Rash	❑ Easy bruising	❑ Intolerance of heat or cold
❑ Cough	❑ Skin ulcers/wound	❑ Easy bleeding	❑ Low blood sugars
❑ Wheezing	❑ None	❑ Abnormal clotting	❑ None
❑ Loud snoring in sleep		❑ Low immunity	
❑ Stop breathing in sleep		❑ None	
❑ 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?

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: _____

_____

Medical History: Check 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? **Yes / No**

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

- ❑ 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.

_____

_____

_____

_____

_____

Family history: Please check which family member has had one of the following medical conditions.

	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 (please circle): Single / Married / Partnered / Widowed / Divorced How many years? _____

What is/was the patient's occupation? _____ Is the patient a veteran? **Yes / No**

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

Who lives in the home with the patient: _____

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

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

If you have any of these documents, please bring a copy to your appointment for our records.

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. **Yes / No / Don't know** Does the patient often repeat him/herself or ask the same questions over and over?
2. **Yes / No / Don't know** Does the patient forget what *month or year* it is?
3. **Yes / No / Don't know** Does the patient *frequently* have trouble finding the words he/she wants to say, finishing sentences, or naming people or things?
4. **Yes / No / Don't know** Is the patient more forgetful, that is, having trouble with short-term memory, on a *daily* basis?
5. **Yes / No / Don't know** Does the patient forget appointments, family occasions, or holidays?
6. **Yes / No / Don't know** Does the patient need reminders to do things like chores or shopping?
7. **Yes / No / Don't know** Does the patient need reminders or other supervision to take medicines?
8. **Yes / No / Don't know** Does the patient have more trouble than usual using gadgets, like the TV remote or phone?
9. **Yes / No / Don't know** Has the patient shown poor judgment, for instance, difficulty making decisions or given money or information to someone inappropriately?
10. **Yes / No / Don't know** Does the patient need help eating, dressing, bathing, or using the bathroom?
11. **Yes / No / Don't know** Does the patient seem sad, down in the dumps, or cry more often than in the past?
12. **Yes / No / Don't know** Has the patient become irritable, agitated, suspicious, or started seeing, hearing, or believing things that are not real?
13. **Yes / No / Don't know / N/A** 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."
14. **Yes / No / Don't know / N/A** 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."

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

Any other symptoms related to memory loss which the patient or their loved ones have noticed and would like to discuss? **Yes / No**

If yes, you may list here: _____

_____

_____

_____

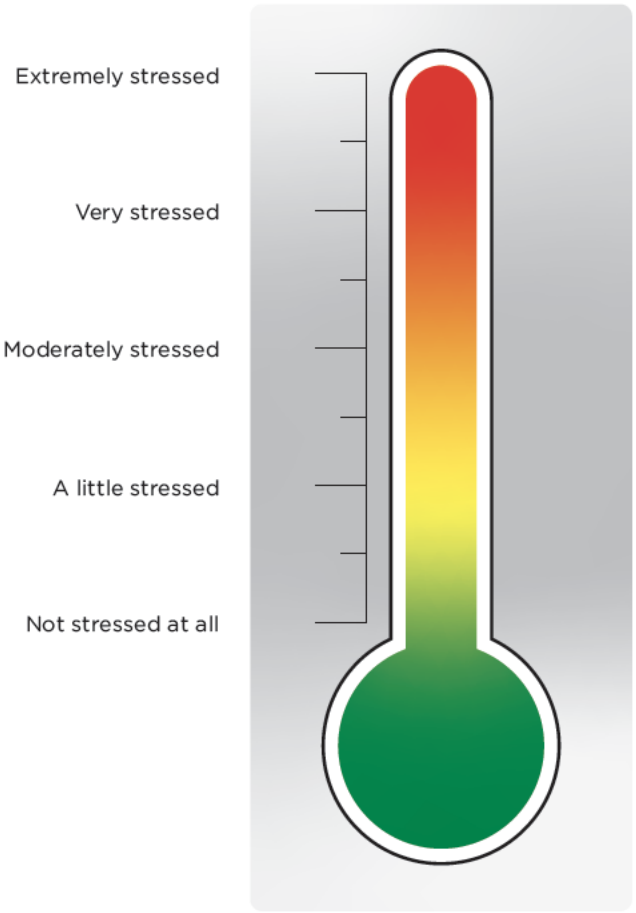
_____

_____

_____

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.