



The Center for Success in Aging
Memory Health Questionnaire

(Please provide the following patient information as accurately and completely as possible. Thank you.)

Today's Date: ___/___/___ Patient Name: _____ [] Male [] Female
Date of Birth: ___/___/___ Age: ___ What is your first language? [] English [] Other _____
Who is the patient's Primary Care Physician? _____

Who is completing this questionnaire? [] Patient [] Family Member or Caregiver

(If a person other than the patient is completing paper work, please provide the following contact information.)

Name: _____ Relationship to patient? _____
Phone: _____ or _____ Email: _____
Mailing Address: _____

What is the reason for this visit? _____

What would be the primary goal(s) for this visit? _____

History of Symptoms

1. Looking back, what symptoms were FIRST Noticed?

- [] Short Term Memory Decline [] Attention/ Concentration
[] Finding words/ Using wrong words [] Behavior in social situations
[] Understanding instructions or information [] Doing things with hands-dressing, using tools
[] Organizing, reasoning, problem solving [] Other _____

2. Looking back, WHEN were symptoms first noticed? _____

3. How did it start? [] Suddenly [] Gradually [] Don't know/Not sure

4. Is it getting worse? [] Rapidly [] Slowly [] Don't know

5. Now, What OTHER Memory and thinking problems are present: Give examples

- [] Short Term Memory Decline _____
[] Finding words/ Using wrong words _____
[] Understanding instructions or information _____
[] Organizing, reasoning, problem solving _____
[] Attention/ Concentration _____
[] Social Behavior _____
[] Difficulty doing things with hands- drawing, writing, dressing _____
[] Difficulty seeing things appropriately _____

6. Have any of the following changes in the usual behavior been present during the course of the illness?
 (Check all that apply.)

Believe that others are stealing or planning to harm them in some way?	
Hear or see things that others do not? Hear voices? Talk to people who are not there?	
Stubborn and resistive to help from others?	
Sad or in low spirits? Increased crying? Withdrawn?	
Become upset when separated from loved one? Other signs of nervousness, such as shortness of breath, sighing, being unable to relax or feeling excessively tense?	
Appear to feel too good or act excessively happy?	
Seem less interested in usual activities, previous hobbies, and the plans of others?	
Act impulsively? Talk to strangers as if know them or say things that may hurt people's feelings?	
Impatient or cranky? Has difficulty coping with delays or waiting for planned activities?	
Engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly? Paces around? Excessively fidgety?	
Up during the night, rise too early in the morning, or take excessive naps during the day?	
Lost or gained weight or had a change in the food liked?	
Other:	

Medication History

Allergies: Please list any drug or food allergies and describe the reactions.

****Please bring all bottles of medications, vitamins, and supplements to the appointment.****

Medical History

Please check all that apply.

Heart / Cardiovascular	
Angina/chest pain/chest pressure	
Atrial Fibrillation/Irregular heart beat	
Cardiac Bypass procedure	
Pacemaker/Defibrillator	
Stent or Balloon placed in blood vessel	
High blood pressure	
High cholesterol	
Congestive heart failure	
Brain and Nervous System	
Stroke/TIA (mini-stroke)	
Parkinson's Disease	
Epilepsy/Seizures	
Multiple Sclerosis	
Headaches	
Tremors	
Head Injury	
Learning or reading difficulties as a child	
Mental Health	
Schizophrenia	
Anxiety	

Depression	
Post Traumatic Stress Disorder	
Bipolar Disorder	
Additional Health Concerns	
Hearing loss	
Vision impairment	
Emphysema, COPD	
Diabetes	
Kidney Disease	
Lupus, Rheumatoid arthritis	
Vasculitis, Temporal Arteritis	
Cancer	
Thyroid	
Anemia	
B12 Deficiency	
Obstructive Sleep Apnea	
Infections:Lyme disease,AIDS, syphilis, etc.	
Other	

Hospitalizations, Surgeries, and Skilled Nursing Home Facility Visits

Please list all surgeries, visits to hospitals, and visits to skilled nursing facilities within the last 5 years.

Month/Year	Name of Hospital/Facility	Reason for Visit

Add additional sheet of paper if necessary.

Please list family history (parents & siblings) of cardiovascular disease, neurological disorders, or dementia.

Who / Relationship	Type of problem

Social History

1. Where does the patient currently live? Home alone, Home with spouse, Home with child,
 Apartment, Assisted Living Facility, Other _____
2. How much school did the patient complete? Less than 8th grade Some high school GED
 High school graduate Some college College degree _____ Graduate school degree _____
3. What type of work did the patient do before retiring?: _____
4. Is the patient or spouse a veteran? Yes No; Was there service during war-time? Yes No
5. Are there firearms in the home? Yes No; If yes, are they safely locked? Yes No
6. Does the patient currently drive? Yes No; If yes, have there been any concerns in this area (i.e. accidents, near misses, getting lost): _____
7. Does the patient exercise? Yes No; If yes, please describe what type and how often: _____

8. Have there been any major recent life changes? Loss of a child Loss of a spouse Retirement
 Moving Medical change Other: _____
9. Does the patient have any of the following documents in place? Durable Power of Attorney
 Health Care Power of Attorney Living Will DNR (Do not Resuscitate) ****Please bring copies**
If these documents are not in place, would you like assistance with this? Yes No
10. Does the patient have a religious or spiritual preference or affiliation? Yes No; If yes, what is the faith background? _____ If yes, is this a source of support/encouragement? Yes No
11. Are there concerns about his/her financial situation? Yes No; If yes, what are the concerns?

12. What is the plan for care for the long term? _____

Screening

1. How many falls has the patient had in the past twelve months? None 1-3 4-6 more than 6
 - 1a. Were these falls associated with: balance tripping dizziness loss of consciousness
 - 1b. Is there a fear of falling? Yes No
2. Does the patient use assistive devices for mobility? Cane Walker Wheelchair
3. Does the patient wear: Hearing aids Glasses
4. Does the patient smoke cigarettes or use other tobacco products (cigars, cigarillos, chewing tobacco, snuff, pipe)? Yes No If yes, please describe: _____
Has the patient stopped using tobacco products? Yes No; If yes, when? _____
5. How much alcohol (wine, beer, liquor) does the patient drink?
 None Less than once a week A few days a week Daily
Has the patient ever had a problem with alcohol use? Yes No
Has anyone ever been concerned about the patient's drinking? Yes No
6. Has the patient lost or gained ten pounds within the past year without trying? Yes No
If yes, please describe: _____

Activities of Daily Living

Choose which applies for each activity: Independence or Dependence.
Place # of points (1 or 0) in the blank for each activity.

<i>Activities</i>	<i>Independence (1 Point)</i>	<i>Dependence (0 point)</i>
	<i><u>NO</u> supervision, direction or personal assistance</i>	<i><u>WITH</u> supervision, direction, personal assistance or total care</i>
Bathing Points: _____	Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity (1 point)	Needs help with bathing more than one part of the body, getting in and out of the tub or shower. Requires total bathing. (0 Points)
Dressing Points: _____	Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes. (1 point)	Needs help with dressing self or needs to be completely dressed. (0 Points)
Toileting Points: _____	Goes to the toilet, gets on and off, arranges clothes, cleans genital area without help. (1 point)	Needs help transferring to the toilet, cleaning self or uses bedpan or commode. (0 Points)
Transferring Points: _____	Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable. (1 point)	Needs help in moving from bed to chair or requires a complete transfer. (0 Points)
Continance Points: _____	Exercises complete self control over urination and defecation. (1 point)	Is partially or totally incontinent of bowel or bladder. (0 Points)
Feeding Points: _____	Gets food from plate into mouth without help. Preparation of food may be done by another person. (1 point)	Needs partial or total help with feeding or requires parenteral feeding. (0 Points)
Total Points _____		

Instrumental Activities of Daily Living

Read the group of statements under each category and circle ONE number that best describes the current highest level of functioning.

A. Ability to Use Telephone

1. Operates telephone on own initiative, looks up and dials numbers.....1
2. Dials a few well-known numbers.....1
3. Answers telephone, but does not dial.....1
4. Does not use telephone at all0

B. Shopping

1. Takes care of all shopping needs independently.....1
2. Shops independently for small purchases.....0
3. Needs to be accompanied on any shopping trip.....0
4. Completely unable to shop.....0

C. Food Preparation

1. Plans, prepares, and serves adequate meals independently.....1
2. Prepares adequate meals if supplied with ingredients.....0
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet.....0
4. Needs to have meals prepared and served.....0

D. Housekeeping

1. Maintains house alone with occasional assistance (heavy work).....1
2. Performs light daily tasks such as dishwashing, bed making.....1
3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness.....1
4. Needs help with all home maintenance tasks.....1
5. Does not participate in any housekeeping tasks.....0

E. Laundry

1. Does personal laundry completely.....1
2. Launders small items, rinses socks, stockings. Etc.1
3. All laundry must be done by others.....0

F. Mode of Transportation

1. Travels independently on public transportation or drives own car.....1
2. Arranges own travel via taxi BUT does not otherwise use public transportation.....1
3. Travels on public transportation when assisted or accompanied by another.....1
4. Travel is limited to automobile or taxi with assistance of another.....0
5. Does not travel at all.....0

G. Responsibility for Own Medications

1. Is responsible for taking medication in correct dosages at correct time.....1
2. Takes responsibility if medication is prepared in advance in separate dosages.....0
3. Is not capable of dispensing own medication.....0

H. Ability to Handle Finances

1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank).....1
2. Manages day-to-day purchases but needs help with banking, major purchases, etc.1
3. Is incapable of handling money.....0