Memory Loss Questionnaire:

Who is filling out this form? (Circle)

Patient   Family Member (relation :________)   Friend   Caregiver

Name of the person filling out the form: ____

If you are other than the PATIENT, please go to "Dementia Questionnaire"
If you are the PATIENT, answer below mentioned questions:

Describe what type of problems you are having with your cognition (memory) (give examples): ___________
____
____
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____

How long you are having problem with memory / cognition? ________ Years

Was the onset sudden or gradual in nature?

Have you ever had significant head trauma?   Yes/ No   If Yes, describe ______________________________

Do you have family history of dementia?   Yes / No   If Yes, in whom ______________________________

Do you have history of ADD / ADHD as child?   Yes / No

Do you snore?   Yes / No

Do you have hearing impairment   Yes / No

Do you take any sleeping pills (e.g. Benadryl, Ambien, etc.) Yes / No ___________________________________

Have you started any new medication lately? Yes / No, If yes, Which medication: ___________________

Do you drink significant amount of alcohol? Yes / No

Any recent major life event or stressful situation? Yes / No, If yes, Describe ______________________________
____

Deficits in my memory significantly hampers my daily functioning?   Yes / No

Frequent feelings of boredom, loss of interest, feeling of hopelessness or helplessness?   Yes / No

Low motivation to do things that were previously enjoyed?   Yes / No

Do I have apathy, agitation, anxiety, irritability?   Yes / No

I see things which are not there (visual hallucinations)?   Yes / No

Have you had any laboratory work done for your memory problem? Yes / No If Yes, details ________________

Have you had any brain scan done for your memory problem? Yes / No   If Yes, details ________________

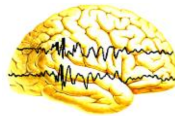
Are you involved in legal matter due to your cognitive problem?   Yes / No

Any other details that we should be aware of? ____
____

For physician use:

Education (Achievement), Treatments, vayacog, axona, Substance, Lumosity.com, Brain food cook book "mindfull", www.alz.org, www.smokefree.gov, Exercise DVD, Stress relaxation CD

Patient Name: ____   DOB: _________________



Dementia Questionnaire:

If you are the PATIENT filling out this form, please go to "Memory Loss Questionnaire"
If you are other than the PATIENT, answer below mentioned questions

When was the first time other people recognized that the patient's cognition was not normal? _______________
Give example ____

Was the progression (circle): sudden / gradual
What were the things the patient was able to do before that he/she is not able to do anymore? _______________
____
____

Is the patient able to manage his/her finances? Yes / No   If Yes: made any mistakes? ____________________
____

Is the patient driving? Yes / No   If Yes: made any mistakes / gets lost? ______________________________
If No: when did patient stop driving? __________   Why? ____
____

Does the patient have "wandering" episodes? Yes / No____
Does the patient have gait impairment. Yes / No____
Does the patient have difficulty following conversations / TV shows / sports etc.? ________________________
Does the patient have difficulty learning new information? Yes / No   If yes, example:____________________
____

Does the patient have good control of bowel and bladder? Yes / No   if No, how long? __________________
____

Are there any changes in the patient's personality / behavioral changes? (Circle): irritable / moody / angry / suspicious / outbursts/ restlessness / withdrawn.
Does patient have (circle): clinging / crying easily / hallucination (seeing or hearing things which are not there) / delusion (firmly held belief in things that are not true - ____)
Does patient have socially unacceptable behavior such as (circle) – cursing, poor personal hygiene, hyper sexuality.

Which activities of daily living patient need help with (circle): ambulation, bathing and hygiene, feeding, continence, grooming, toileting and dressing.

Does patient has sleep impairment? Yes / NO, if yes explain: ________________
Does patient gets confused between day and night? Yes / No
Are there any repetitive, purposeless behaviors?: (Circle) hand-wringing, scratching, hollering, _____________
Medications use (circle appropriate): patient self medicates, family monitors medication usage, family sets up medications, home health aide sets up medications and caregiver monitors the use of medications.
Can patient be left alone? Yes / No
Patient's primary caregiver is (circle) : daughter, spouse, son, friend, sibling, adult caretaker, nursing attendant, partner

For physician use only:
Safety (wandering – GPS, medical alert / fire arm access), Living will, Code status, Health care power of attorney, Long term care planning, driving, care giver fatigue
Intervention: music, dance, walk, commands – one word, family pictures/videos, pet, friend circle, church

Patient Name: ____________________________________   DOB: ________________