THOMSON MEMORY CENTER

PATIENT NAME:

M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE

INSTRUCTIONS FOR COMPLETING

Please answer the following questions about your health and history. Although this form is lengthy, it is designed to be very thorough. Completing this information before your appointment will greatly assist the doctor to best use your assessment time with her /him by enabling a more detailed focus.

Name of Patient: _____ Date of Evaluation: _____

If form not completed by patient, name of person completing & relationship to patient:

_____ _____

NAME **RELATIONSHIP TO PATIENT**

_____

PHONE NUMBER

DEMOGRAPHICS

STREET:_____ APT: _____

CITY: _____ STATE _____ ZIP: _____

PHONE (Home): _____ Cell:_____

DATE OF BIRTH: _____ AGE:_____ yrs

SEX: o Male o Female HANDEDNESS: o Right o Left o Ambidextrous

Ethnicity origin (or Race): Please circle your ethnicity.

Native American Asian African American Caucasian

Hispanic Other

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Who is your primary doctor? Dr. _____

Address: _____

Phone number: ( ) _____

Fax Number: ( ) _____

May we contact your physician? Yes No

REFERRAL INFORMATION

Who referred you to the Thomson Memory Center? _____

- If referred by a specific physician, mental health care provider, or other specialist, please provide his/her name, specialty and contact information below:

  Name: _____ Specialty: _____

  Address: _____

  Phone number: ( ) _____

  Fax number: ( ) _____

PRESENTING PROBLEM

Please briefly describe what problem(s) with thinking you are experiencing:

_____

_____

_____

_____

_____

_____

_____

_____

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Did these changes have an abrupt onset (for example, normal one day and then problems the next)? Yes No

Did these changes have a gradual onset (for example, slowly negatively progressing over time)? Yes No

Please describe how long the patient has been experiencing these problems and a brief description of the course (for example, gradual onset starting 3 years ago but a more noticeable decline in the past 6 months).

_____

_____

_____

Have you noticed any of these additional symptoms? Please check those that apply to you.

A. Attention

- o Easily distracted
- o Difficulties staying on task
- o None of the Above

B. Memory

- o Ask same question repeatedly
- o Difficulties with making or keeping appointments
- o Forgetting recent conversations
- o Forgetting why you went into room
- o Forgetting where things are in the kitchen
- o None of the Above

C. Language

- o Trouble summoning words (the word feels like it is on the tip of your tongue)
- o Stopped reading
- o Mispronounce or use wrong words
- o Handwriting has deteriorated
- o Trouble recalling names of long time acquaintances
- o None of the Above

D. Visuospatial function

- o Confused or disoriented in stores or malls
- o Getting lost easily even on familiar routes
- o Trouble finding the car in the parking lot
- o Difficulty driving: number of accidents and when:
- o None of the Above

E. Executive Function

- o Feeling unorganized
- o Lacking motivation
- o Personality changes
- o Embarrassing or inappropriate in social gatherings
- o Difficulties with hygiene-bathroom use
- o Difficulties with negative evaluations at work
- o None of the Above

F. Praxis

- o Difficulties using household items
- o Trouble dressing (two socks on one foot, shirts on backwards)
- o None of the Above

G. Vision

- o Blurred vision
- o Groping for door handles
- o None of the Above

H. Emotional

- o Sadness
- o Anxiousness
- o Social problems
- o None of the Above

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What are your typical daily activities? Please respond below.
Would you consider these activities a change from what you used to do? Yes No

_____

_____

_____

Do you drive a vehicle? Yes No

Please indicate if you are independent or need help with any of the following.

TASK	DON'T NEED HELP	NEED HELP	WHO HELPS
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money / financial			
Doing laundry			
Doing housework			
Grocery shopping			
Driving			
Doing "handyman" tasks			
Climbing stairs			
Getting to places beyond walking			

Do you employ someone to provide care or help you in your home? Yes No

If "yes," how many hours a day? _____ How many days a week? _____

Do you get help from a family member or friend in your home? Yes No

If "yes," how many hours a day? _____ How many days a week? _____

Do you provide care for a family member? Yes No

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PAST MEDICAL HISTORY

Please check all medical conditions that you have or have had in the past:

I. EYE & EAR PROBLEMS

a) o Cataracts
b) o Glaucoma
c) o Macular degeneration of the eye
d) o Hearing loss/hearing aid
e) o Other, specify: _____

II. HEART PROBLEMS

a) o Heart attack: year_____
b) o Heart failure
c) o High blood pressure
d) o Irregular heartbeats (arrhythmias)
e) o Aortic stenosis
f) o Other, specify: _____

III. LUNG PROBLEMS

a) o Asthma
b) o Bronchitis
c) o Emphysema
d) o COPD
e) o Other, specify: _____

IV. BONE & JOINT PROBLEMS

a) o Arthritis
b) o Osteoporosis
c) o Gout
d) o Fracture (circle which one(s)) hip/wrist/spine
e) o Other, specify: _____

V. GLAND PROBLEMS

a) o Diabetes
b) o Thyroid (overactive/high)
c) o Thyroid (underactive/low)
d) o Other, specify: _____

VI. KIDNEY & URINARY TRACT PROBLEMS

a) o Kidney disease
b) o Prostate disease
c) o Frequent bladder or kidney infections
d) o Urinary incontinence
e) o Other, specify: _____

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VII. GASTROINTESTINAL PROBLEMS

a) o Ulcers
b) o Heartburn/hiatal hernia
c) o Diverticulosis
d) o Liver disease/Cirrhosis
e) o Hepatitis
f) o Polyps
g) o Gallbladder disease
h) o Other, specify: _____

VIII. NERVOUS SYSTEM PROBLEMS

a) o Stroke
b) o Dementia or Alzheimer's
c) o Parkinson's Disease
d) o Epilepsy or Seizures
e) o Exposure to toxins
f) o Head Injury (# of occurrences) _____
Dates: _____
g) o Other, specify: _____

IX. OTHER HEALTH PROBLEMS

a) o Allergies (specify): _____
b) o High Cholesterol
c) o Anemia
d) o Hernia
e) o Thrombosis (blood clots)
o of leg o of lung
f) o Sleep Apnea
Treatment: _____
g) o Cancer (of what): _____
h) o Psychiatric problems:
o anxiety o depression
o psychosis o bipolar
o other: _____
i) o Sexual function problems (specify): _____

X. RECENT MEDICAL SYMPTOMS

a) o Loss of consciousness or near fainting
b) o Dizziness
c) o Migraines
d) o Changes in smell or taste
e) o Hallucinations
f) o Changes in appetite
g) o Loss of urine or getting wet
h) o Numbness or arm/leg weakness
i) o Sleep problems (specify):
o Falling asleep
o Staying asleep
j) o Tremor or Shaking
k) o Problems with falling or loss of balance

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List surgeries (operations). Use additional page, if needed.

SURGERY	DATE
1.	
2.	
3.	
4.	
5.	
6.	

List Other Hospitalizations. Use additional page, if needed.

HOSPITALIZATION REASON	DATE
1.	
2.	
3.	
4.	
5.	

List any neuroimaging (e.g., CT scan, MRI of the head/brain). Use additional page, if needed.

NEUROIMAGING TECHNIQUE	DATE	ORDERING PHYSICIAN
1.		
2.		
3.		
4.		
5.		
6.		

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Do you have any drug allergies? No Yes: specify below

NAME OF DRUG	REACTION
1.	
2.	
3.	

List all medicines that you use. (prescription, non-prescription & natural products)

NAME OF MEDICATION	STRENGTH	HOW OFTEN PER DAY
Example: Tylenol	*500 mg*	*1 pill 3 times a day*
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

o Daily o Almost daily (4 to 6 times a week)
o 1 to 3 times a week o Less than 1 time a week o Never

If you drink alcohol, has anyone ever been concerned about your drinking? Yes No

Have you ever sought treatment due to a drinking problem? Yes No

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Have you ever used tobacco? Yes No

- **If "yes,"** are you now smoking? Yes No
  How many years have you smoked? _____
  How much do you smoke? (check all that apply)
  o Cigarettes: _____ packs per day o E-cigarettes/Vaping: _____ times per day

- **If you have smoked in the past but are not currently smoking,** how many years ago did you quit? ____ For how many years did you smoke? _____ How many packs per day did you smoke? ____

Have you ever used illicit/recreational drugs? Yes No

- If yes, please specify types(s) of drugs, frequency of use, and if you currently use illicit/recreational drugs.

_____

_____

_____

FAMILY HISTORY

Have any members of your family had any of the following conditions? (check all that apply)

- o Dementia or Alzheimer's Disease
- o Diabetes
- o Depression
- o Psychiatric Problems: (specify)
  _____
- o Heart disease
- o Stroke
- o Cancer: of what ? _____
- o Anxiety
- o Other (specify): _____

SOCIAL HISTORY

Please check the appropriate response for each question below:

With whom do you live?

- o Alone
- o Spouse or partner
- o Child or other family member
- o Others, not family
- o Other, specify: _____

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Which of the following best describes your residence?

- o Single-family house
- o Condo or apartment
- o Live with other in their home
- o Retirement hotel
- o Board and care/residential care facility
- o Nursing Home
- o Other, specify: _____

Are you currently:

- o Married
- o Divorced / Separated
- o Widowed
- o Single / Never married
- o Living with Significant Other

Did you or your spouse serve in the military? Yes No

How many children do you have? _____
Are you in regular contact with your children? Yes No

How much school did you complete?

- o Less than 6th grade
- o Less than high school graduate
- o High school graduate
- o Some college
- o College graduate
- o More than college graduate

Total number of educational years: ____

Did you attend trade school? Yes No
Specify trade: _____

Is English your primary language? Yes No
If no, what is your first language? _____

Did you go to school in the United States? Yes No
If no, where? _____

Were any subjects more difficult than the others? Which ones? _____

Did you fail any grades? _____

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What is/was your principal occupation? _____

Are you currently:

o Retired / not working when: _____ o Working part-time o Working full-time

PLANNING FOR FUTURE HEALTH CARE

Do you have a medical Durable Power of Attorney (POA)? Yes No

If yes, who is your POA and relation to you? _____

Do you have a living will? Yes No

Do you have any additional information that you would like the doctor to know about before your visit?

Yes No

_____

_____

_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PHONE (Home): _____ Cell: _____

Thank you for your cooperation and patience in completing this form!