THOMSON MEMORY CENTER

PATIENT NAME:

M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE RE-EVALUATION

INSTRUCTIONS FOR COMPLETING

Please answer the following questions about your health and history. Much of your previous history will be included into the new evaluation; however, there may have been changes since your previous evaluation. We want to continue to ensure full comprehension of your overall complexity. 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

Who is your primary doctor? Dr. _____

Address: _____

Phone number: ( ) _____

Fax Number: ( ) _____

May we contact your physician? Yes No

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M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE RE-EVALUATION

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: ( ) _____

DATE(S) OF PREVIOUS EVALUATION(S):

_____

_____

_____

PREVIOUS DIAGNOSIS/DIAGNOSES:

_____

_____

LIST RECOMMENDATIONS THAT WERE PROVIDED AND YOU ATTEMPTED:

(Please indicate usefulness of recommendation and how long attempted)

_____

_____

_____

_____

PRESENTING PROBLEM AND CHANGES FROM LAST EVALUATION

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

_____

_____

_____

_____

_____

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PRE-VISIT QUESTIONNAIRE RE-EVALUATION

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

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

Please describe how long the patient has been experiencing these problems and a brief description of the course (for example, since the previous evaluation or prior to the previous evaluation with an 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

PATIENT NAME:

M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE RE-EVALUATION

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 Increased difficulty multitasking
- 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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PRE-VISIT QUESTIONNAIRE RE-EVALUATION

What are your typical daily activities? Please respond below.
Is this considered a change since the previous evaluation? o No o Yes

_____

_____

_____

Do you drive a vehicle? o No o Yes

If yes, any issues in driving? (for example, getting lost, distracted, speeding tickets, accidents)

_____

_____

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? o No o Yes

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? o No o Yes

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

THOMSON MEMORY CENTER

PATIENT NAME:
M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE RE-EVALUATION

Do you provide care for a family member? o No o Yes

RECENT MEDICAL CONDITIONS OR AILMENTS (acquired after previous evaluation):

Please list any recent medical conditions including possible head injuries, neurological insults, and heart conditions that have been identified since the previous evaluation

_____

_____

_____

_____

_____

_____

RECENT SURGERIES AND/OR HOSPITALIZATIONS (acquired after previous evaluation):

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

HOSPITALIZATION REASON	DATE
1.	
2.	
3.	
4.	

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PRE-VISIT QUESTIONNAIRE RE-EVALUATION

RECENT NEUROIMAGING PROCEDURES (acquired after previous evaluation):

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.		

RECENT PHYSICAL 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

Have you acquired any new drug allergies? o No o Yes: specify below

NAME OF DRUG	REACTION
1.	
2.	

List all current medications that you use (prescription, non-prescription, & natural products/vitamins)

NAME OF MEDICATION	STRENGTH	HOW OFTEN PER DAY
Example: Tylenol	*500 mg*	*1 pill 3 times a day*
1.		
2.		
3.		
4.		
5.		
6.		

THOMSON MEMORY CENTER

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PRE-VISIT QUESTIONNAIRE RE-EVALUATION

How often do you currently 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? o No o Yes

Have you ever sought treatment due to a drinking problem since previous evaluation? o No o Yes

MENTAL HEALTH

Since previous evaluation have you sought psychotherapy/counseling? o No o Yes

If yes, list the working diagnoses being treated. Please describe the effectiveness of treatment:

_____

_____

_____

_____

Are you currently receiving psychiatric services or prescribed psychotropic medication (e.g., antidepressant, antipsychotic medications, etc.) and if yes by whom? o No o Yes

_____

_____

Have you been psychiatrically hospitalized since the previous evaluation? o No o Yes

If yes, please note reason and list dates.

_____

_____

Are you currently using tobacco products? o No o Yes

- **If "yes,"**
  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? _____

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PATIENT NAME:

M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE RE-EVALUATION

Are you utilizing illicit/recreational drugs? o No o Yes

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

_____

_____

_____

FAMILY HISTORY

Have there been any changes to family medical history since the previous evaluation? *(check all that apply)*

- o Dementia or Alzheimer's Disease
- o Depression
- o Anxiety
- o Psychiatric Problems: *(specify)*:

_____

- o Heart disease
- o Stroke
- o Cancer: of what ? _____
- o Diabetes
- o Other *(specify)*:

_____

PRESENT SOCIAL SITUATION

Have there been any changes to your living situation since the previous evaluation. If so, please described:

_____

_____

_____

With whom do you live?

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

PATIENT NAME:

M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE RE-EVALUATION

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

Have you acquired more education since the previous evaluation, and if so what is your new level of education completed?

- o High school graduate
- o College graduate
- o Some college
- o More than college graduate

Total number of educational years: ____

Were any subjects more difficult than the others? Which ones? _____
Did you fail any courses? _____

Have there been any changes to your work history. If so, what is your current occupation/position?
_____

Are you currently:

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

If retired, are you currently participating in any volunteer activities? o No o Yes

Do you presently receive social disability and if so what type and for how long? o No o Yes
_____

PLANNING FOR FUTURE HEALTH CARE

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

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

Do you have a living will? o No o Yes

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M.R. NUMBER:

PRE-VISIT QUESTIONNAIRE RE-EVALUATION

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

o No o Yes: _____

_____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP: _____

PHONE (Home): _____ Cell:_____

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