

MR# 0

LAST NAME

VISIT DATE

MM / DD / YYYY

FIRST NAME

MM DD YYYY

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UF Memory and Cognitive Disorders Program - Initial Visit Packet

1. Patient Name:

Last Name

First Name

Middle Name

2 Date of birth:

Age

3. Which hand would you normally use to write or throw a ball?

Left-handed

Right-handed

Ambidextrous (both hands)

4 Sex: Male Female

HISTORY OF SYMPTOMS

1. At what age did you develop meaningful changes in memory, thinking, behavior, or the ability to manage your affairs?

2. For how long have these meaningful changes been developing?

3. Do you think these problems are: Getting worse? Getting better? Staying the same?

(COGNITIVE SYMPTOMS) THINKING OR MEMORY PROBLEMS:

3. Looking back, which of these was the first change in ability (even if you didn't realize it at the time)?

Memory

Getting lost

N/A

Judgment and problem solving

Attention/Concentration

Language

Other

4. How did the change start? Gradual (greater than 6 months) Other

Subacute (less than 6 months) N/A

Abrupt (suddenly)

5. How long has this change been developing? Months Years Unknown

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(OFFICE USE ONLY)**(COGNITIVE SYMPTOMS) THINKING OR MEMORY PROBLEMS (continued):**

- | | Yes | No | Unknown |
|---|--------------------------|--------------------------|--------------------------|
| 6. Has there been a meaningful change in your usual abilities for any of the following? If yes, circle all that apply: | | | |
| a. Memory Do you forget dates and/or what people tell you; repeat questions and/or statements; misplace items more than usual; forget names of people you know well? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| b. Judgment and problem-solving: Do you have trouble handling money (tips); paying bills; shopping; preparing meals; handling appliances; driving? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| c. Driving: Any driving accidents, scrapes or near misses during the past year? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| d. Language: Do you have trouble finding words; use the wrong words without realizing it? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| e. Visual-spatial function: Despite normal eyesight, do you have more trouble than usual with getting confused about directions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| f. Attention/concentration: Is it hard to keep paying attention or to stay focused? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| g. Other, If yes, then specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |

BEHAVIOR CHANGES:

- | | Yes | No | Unknown |
|--|--------------------------|--------------------------|--------------------------|
| 7. Which of the following changes in behavior have been present during the course of the illness? If yes, circle all that apply: | | | |
| a. Have you lost interest in or displayed a reduced ability to initiate usual activities and social interaction, such as having a meal with friends or taking a walk? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| b. Have you seemed sad or down for more than two weeks at a time; e.g., loss of interest or pleasure in nearly all activities; sadness, hopelessness, loss of appetite, fatigue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| c. Do you see or hear things that are not there, or misinterpret an everyday object as something else? Do you wonder if missing items have been stolen? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| d. Do you use rough language or exhibit inappropriate speech or behaviors in public or in the home? Do you talk personally to strangers or have disregard for personal hygiene? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| e. Do you find yourself getting angry or impatient with people more often? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| f. Do you have trouble sitting still; do you shout, hit, and/or kick? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |
| g. Other, If yes, then specify: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Unknown |

8. Rate of change:

- Gradual (greater than 6 months) Other _____
 Subacute (less than 6 months) N/A
 Abrupt (suddenly)

9. How long have these behavior changes been developing? Months Years Unknown

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(OFFICE USE ONLY)**MOVEMENT (or ability to move body):****Yes****No****Unknown**

10. Which of the following changes in ability to move have been present during the course of the illness? If yes, circle all that apply:

a. **Changes in walking:** Has your walking changed, not due to arthritis or an injury? Are you unsteady? Do you drag your feet when walking or have little or no arm-swing?

Yes No Unknown

b. **Falls:** Do you seem to fall more than usual?

Yes No Unknown

c. **Tremor:** Do you tremble or shake, especially in the hands, arms, legs, head, mouth, or tongue?

Yes No Unknown

d. **Slowness:** Have you noticeably slowed down in walking or moving or handwriting, other than due to an injury or illness? Has your face become less expressive, "wooden" or masked?

Yes No Unknown

11. Rate of movement change:

Gradual (greater than 6 months)

Subacute (less than 6 months)

Abrupt (Sudden onset)

Other _____

N/A

12. Which ability to move changed **first**? Walking Falling Tremors Slowness N/A

13. How long have these movement changes been developing? Months Years Unknown

PREVIOUS EVALUATION

1. Previous evaluation by Doctor included:

- Blood studies
- MRI Scan
- CT Scan
- PET Scan
- SPECT
- EEG (brain waves)
- Spinal tap
- Sleep study
- EMG (test of muscles)

2. Check if you brought with you today:

- Doctor's records
- Brain scans

Other: _____

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(OFFICE USE ONLY)**PAST MEDICAL HISTORY**

1. Heart disease:	Yes	No	Unknown												
a. Heart attack/cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
b. Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
c. Stent/balloon placed in a blood vessel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
d. Cardiac bypass procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
e. Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
f. Congestive heart failure (fluid in the lungs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
g. Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
2. Cerebrovascular disease:	Yes	No	Unknown												
a. Stroke/transient ischemic attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
If present, indicate years of occurrence:	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
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b. Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
3. Parkinsonian features:	Yes	No	Unknown												
a. Parkinsonism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
If present, indicate year of occurrence:	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>														
b. Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
If present, indicate year of occurrence:	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>														
4. Other brain or genetic conditions:	Yes	No	Unknown												
a. Down's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
b. Huntington's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
c. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
d. Head injury:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
1) with brief loss of consciousness (< 5 min.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
2) with extended loss of consciousness (> 5 min.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
3) with chronic deficit or dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
e. Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
f. Learning or reading difficulties as a child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												

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5. Medical conditions: **Yes** **No** **Unknown**

- a. High blood pressure
- b. High cholesterol
- c. High blood sugar
- d. B12 deficiency
- e. Thyroid disease
- f. Obstructive sleep apnea
- g. Liver disease
- h. Kidney failure
- i. Cancer (note types): _____
- j. Infections: i.e., AIDS, Lyme disease, syphilis, etc.
- k. Migraine

6. Depression (sadness for 6 months or more): **Yes** **No** **Unknown**

- a. Experienced within past 2 years
- b. Other times when you were diagnosed with depression

7. Psychiatric disorders:

- Schizophrenia Major Depressive Disorder Bipolar Disorder
- Anxiety Post Traumatic Stress Disorder Other

8. Please list other problems not mentioned:

9. Past Surgical History: Please list any surgeries you have had in the past (for example: heart surgery, repair of broken bones, mastectomy, etc.):

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10. Allergies, and Bad Reactions to Medicine or Food:

Yes No Unknown

If yes, please list all allergies with type of reaction (for example: itching, rashes, swelling, difficulty breathing):

11. Current Medicines (include Medicines for Memory; and, Vitamins, Minerals, Herbs, and Supplements)
(For example: Aspirin 325 mg one pill twice a day):

If taken twice daily:

Memory Medicines: Dose One: Dose Two

- Aricept mg mg
- Exelon . mg . mg
- Razadyne IR mg mg
- Razadyne ER mg mg
- Namenda mg mg

12. Past medicines taken for memory: 13. Stopped for side effects? 14. Other reasons:

- Aricept Yes
- Exelon Yes
- Razadyne IR Yes
- Razadyne ER Yes
- Namenda Yes

Other Past Medications for Memory:

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Family History

For the following questions, "dementia" refers to progressive memory loss noted as senility, dementia, Alzheimer's Disease, hardening of the arteries, or other causes that interfered with memory or thinking ability, and from which they did not recover. Please consider blood relatives only.

PARENTS:

- 1. Did your mother have dementia (as defined above)? Yes No Unknown
a. If yes, please write her age when her dementia symptoms began.
b. If living, please write in her current age.
c. If not living, please write in her age at death.
d. Please write in her cause of death.

- 2. Did your father have dementia (as defined above)? Yes No Unknown
a. If yes, please write his age when his dementia symptoms began.
b. If living, please write in his current age.
c. If not living, please write in his age at death.
d. Please write in his cause of death.

SIBLINGS:

- 3. How many fully related brothers or sisters do you have? Unknown
4. How many of these brothers and/or sisters have dementia (as defined above)? Unknown
Age at onset Current age if living
a. Sibling 1 (years) (years)
b. Sibling 2 (years) (years)
c. Sibling 3 (years) (years)
d. Sibling 4 (years) (years)
e. Sibling 5 (years) (years)

CHILDREN

- 5. How many biological (birth) children do you have? Unknown
6. How many of these children have dementia (as defined above)? Unknown
Age at onset Current age if living
a. Child 1 (years) (years)
b. Child 2 (years) (years)



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OTHER RELATIVES:

7. Number of other blood relatives with dementia (as defined above) (cousins, aunts, uncles, grandparents)

a. Mother's side of family [] [] Unknown

b. Father's side of family [] [] Unknown

8. For each other blood relative with dementia, indicate age at onset and current age if living:

	<u>Age at onset</u>	<u>Current age if living</u>
a. Relative 1	[] [] [] (years)	[] [] [] (years)
b. Relative 2	[] [] [] (years)	[] [] [] (years)
c. Relative 3	[] [] [] (years)	[] [] [] (years)
d. Relative 4	[] [] [] (years)	[] [] [] (years)
e. Relative 5	[] [] [] (years)	[] [] [] (years)
f. Relative 6	[] [] [] (years)	[] [] [] (years)

9. *For each of the disorders mentioned below, indicate which family member had the illness (M=mother; F=father; B=brother; S=sister; GF=grandfather; GM=grandmother; O=other).

- | | |
|---|----------------------------------|
| _____ Dementia | _____ Cancer (what types?) _____ |
| _____ Migraine | _____ Diabetes |
| _____ Muscle problems | _____ Heart disease |
| _____ Neuropathy (disease of nerves) | _____ High blood pressure |
| _____ Parkinson disease | _____ Other: _____ |
| _____ Seizure disorder (epilepsy) | |
| _____ Stroke | |
| _____ Any other neurologic disease: _____ | |



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Social History

1. What is your highest level of education attained?

- Less than High school If less than high school or GED please indicate number of years completed: [] []
- GED Grades repeated: _____
- High school How many years of college total? [] []
- Associates
- Bachelors
- Masters
- Doctorate

2. Are you presently in school? Yes No

3. Are you presently employed? No Part Time Full Time

If so, current position/job title: _____

4. Do you volunteer? No Part time Full time

5. Are you retired? Yes No If so, prior paid job: _____

6. Disabled? Yes No Unknown

7. What is your primary home? (Where do you live most of the time?)

- Own home Skilled nursing facility/nursing home
- Relative/friend's home Other
- Retirement community Unknown
- Assisted living/boarding/adult family home

8. Do you live alone? Yes No

9. If no, who do you live with?

- Spouse Friend/neighbor
- Child Paid caregiver/provider
- Sibling Other _____
- Other relative



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Social History (continued)

10. Primary residence zip code: [] [] [] [] [] []

11. Do you live independently (require no assistance)? Yes No

12. Current marital status:

Married

Widowed

Divorced

Separated

Never married

Other (e.g., partner)

13. What is your primary race?

*Prefer not to answer

White

African American

American Indian or Alaska Native

Native Hawaiian or Pacific Islander

Asian

Other

Unknown

14. Are you Hispanic/Latino?

*Prefer not to answer Yes No Unknown

15. What is your primary language?

English Other

Spanish Unknown

16. What is your secondary language?

English Other

Spanish Unknown

17. What is your tertiary language?

English Other

Spanish Unknown

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18. Alcohol, Tobacco, and Other Drug Use	Yes	No	Unknown
a. Alcohol use or abuse			
1) Do you drink alcohol currently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) If so, how much? _____			
3) Have you drank alcohol regularly in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) If so, how much? _____			
5) When did you stop? _____			
6) Due to alcohol, have you ever had significant impairment over a 12-month period affecting one of the following: work, driving, legal, money decisions or social?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Tobacco use or abuse (including cigarettes, cigars, pipes, chewing tobacco, etc.)			
1) Have you smoked within last 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Have you smoked more than 100 cigarettes in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Total years smoked: <input type="text"/> <input type="text"/> <input type="checkbox"/> Unknown			
4) If stopped, how long ago? _____			
5) Average number of packs smoked each day:	<input type="checkbox"/> < 1/2 pack	<input type="checkbox"/> 1 1/2 - < 2 packs	
	<input type="checkbox"/> 1/2 - < 1 pack	<input type="checkbox"/> > 2 packs	
	<input type="checkbox"/> 1 - 1 1/2 pack	<input type="checkbox"/> Unknown	
c. Tobacco exposure			
1) Does anyone in your home smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
2) How many hours a day are you exposed to tobacco smoke?	<input type="checkbox"/> < 1 hour	<input type="checkbox"/> > 4 hours	
	<input type="checkbox"/> 1 to 4 hours	<input type="checkbox"/> Not exposed	
d. Other used or abused substances			
1) Have you used recreational drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, specify: _____			
2) Due to recreational drugs, have you had difficulty over 12 months in one of the following: work, driving, legal, money decisions, or social.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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Review of Systems (check all that apply to how you are feeling today)

General Health:

- Overall health has been good.
There has been more than a 10 pound weight loss/gain...
Sleeps poorly?
Daytime sleepiness?

Mental Health:

- Sad or depressed?
Enjoys life and doing things?
Sees or hears people or things who are not there?

Nervous System:

- Headaches?
Trouble walking?
Weakness?
Numbness?
Shaking?
Passing out?
Staring spells?
Dizziness?
Falls without passing out?

Genitourinary:

- Trouble holding back urine?
Burning with urination?
Abnormal bleeding?

Heart:

- Severe chest pains?
Palpitations?
Irregular heartbeats?

List any other symptoms not mentioned above:

Lungs:

- Short of breath?
Cough?
Blood with cough?

Hormone System:

- Always warm or cold?
Always warm?
Always cold?

Skin:

- Any rashes?
Any skin growths or changes in moles?

Gastrointestinal:

- Good appetite?
Pains in stomach?
Frequent heartburn?
Blood in stool?
Diarrhea/constipation?
Diarrhea
Constipation

Bone System:

- Joint pains or stiffness?
Muscle aches or pains?

Vision:

- Good (without glasses)?
Good (with glasses)?
Cataracts?
Cataract surgery?

Hearing:

- Good (without hearing aids)?
Good (with hearing aids)?
Hearing aids?

PMH, FH, SH reviewed by: / Date:

Provider Signature: / Date:

Provider #

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Information on person filling out form

1. How did you hear about us?

- Radio
- Print advertisement
- Memory screening activity
- Memory Walk
- Consulting physician
- Referring program
- Friend/relative
- Podcasts
- Other _____

2. Is someone other than the patient filling out this form?

- Yes (please answer the other questions on this page)
- No (skip the rest of this page)

3. If so, what is the person's relationship to the patient?

- Spouse
- Friend/neighbor
- Child
- Paid caregiver/provider
- Sibling
- Other _____
- Other relative

4. Informant's month/year of birth: [] [] / [] [] [] []

5. Informant's sex: Male Female

6. What is your highest level of education attained?

- Less than High school If less than high school or GED please indicate number of years completed: [] []
- GED
- High school
- Associates How many years of college total? [] []
- Bachelors
- Masters
- Doctorate

7. Does the informant (person filling out form) live with the patient?

- Yes No

8. If no, how often does the informant visit (and help) the patient:

- Daily Weekly Monthly Less than once a month

9. What is your primary race?

- Prefer not to answer
- Asian
- Other
- White
- Native Hawaiian or Pacific Islander
- Unknown
- African American
- American Indian or Alaska Native

10. Are you Hispanic/Latino?

- Prefer not to answer Yes No

11. What is your primary language?

- English Other
- Spanish Unknown

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Our doctors will send a report to you and the requesting physician:

Requesting Physician: _____

Address: _____

City: _____ State: [] [] Zip: [] [] [] [] [] []

Patient Address: _____

City: _____ State: [] [] Zip: [] [] [] [] [] []

Please indicate if you want a copy sent to someone else:

Other: _____

Address: _____

City: _____ State: [] [] Zip: [] [] [] [] [] []

Other: _____

Address: _____

City: _____ State: [] [] Zip: [] [] [] [] [] []

Who has the legal ability to make medical decisions for the patient?

Relationship to patient?

Who may we discuss your medical care with?

Relationship to patient?

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