Elliot Memory
& Mobility Center
Preserving Independence

Please mail back in the enclosed envelope if time permits. Otherwise, bring this form to your appointment at _____ am/pm on:

_____

PRE-VISIT MEDICAL QUESTIONNAIRE

INSTRUCTIONS

Please answer the following questions about your medical health. Although this form is lengthy, it is designed to be very thorough. Completing this information before your appointment will greatly assist the doctor to be focused in your exam and best use your time together.

Name of Patient: _____ Date of Evaluation: _____

If you are completing this form on behalf of the patient, please fill in this box:

_____ _____
NAME RELATIONSHIP TO PATIENT

_____
PHONE NUMBER

DEMOGRAPHICS

STREET: _____ APT. _____

CITY: _____ STATE _____ ZIP: _____

PHONE (Home): _____ Cell: _____

DATE OF BIRTH: _____ AGE: _____ SEX: ❑ Male ❑ Female

Who is your **primary doctor**? Dr. _____
Current or most recent primary physician

Address: _____

_____

Phone number: ( ) _____

Fax Number: ( ) _____

PRESENTING PROBLEM

Who referred you to the Memory Clinic? _____

May we contact the referring physician? ☐ No ☐ Yes

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

_____

_____

_____

_____

_____

_____

_____

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

Did these changes have a **gradual onset** (for example, slowly worsening over time)? ☐ No ☐ Yes

Please describe **when** the problems started, and the **pattern** of the problems up until the present:

_____

_____

_____

Have you noticed any of these additional symptoms? Please check those that apply to you and provide an example in the space below (for example: if you answer yes to being easily distracted, your example may be "difficulties watching full TV show").

A. Attention

☐ No ☐ Yes Easily distracted

☐ No ☐ Yes Difficulties staying on task

_____

_____

_____

B. Memory

☐ No	☐ Yes	Asking same question repeatedly
☐ No	☐ Yes	Difficulties with making or keeping appointments
☐ No	☐ Yes	Forgetting recent conversations
☐ No	☐ Yes	Forgetting why you went into room
☐ No	☐ Yes	Forgetting where things are in the kitchen

C. Language

☐ No	☐ Yes	Can't think of the right word (" tip of your tongue" experience)
☐ No	☐ Yes	Stopped reading
☐ No	☐ Yes	Mispronouncing or using wrong words
☐ No	☐ Yes	Handwriting has deteriorated
☐ No	☐ Yes	Trouble recalling names of long time acquaintances

D. Visuospatial function

☐ No	☐ Yes	Confused or disoriented in stores or malls
☐ No	☐ Yes	Getting lost easily even on familiar routes
☐ No	☐ Yes	Trouble finding the car in the parking lot
☐ No	☐ Yes	Difficulty driving—number of accidents and when:

E. Executive Function

☐ No ☐ Yes Feeling disorganized
☐ No ☐ Yes Personality changes
☐ No ☐ Yes Embarrassing or inappropriate behavior in social gatherings
☐ No ☐ Yes Difficulties with hygiene or toilet use
☐ No ☐ Yes Difficulties with negative evaluations at work

F. Praxis

☐ No ☐ Yes Difficulties using household items
☐ No ☐ Yes Trouble dressing (wrong apparel for the weather, shirt inside out, etc.)

G. Vision

☐ No ☐ Yes Blurred vision
☐ No ☐ Yes Groping for door handles

Time and Leisure: When alone, what do you do?

Would you consider these activities a change from what you used to do? ☐ No ☐ Yes

PAST MEDICAL HISTORY

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

I. EYE & EAR PROBLEMS

__none

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

__none

a) o Heart attack: year_____
b) o Heart failure
c) o High blood pressure
d) o Irregular heart beats (arrhythmias)
e) o Other, specify: _____

_____

III. LUNG PROBLEMS

__none

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

_____

IV. BONE & JOINT PROBLEMS

__none

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

_____

V. GLAND PROBLEMS

__none

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

_____

VI. KIDNEY & URINARY TRACT PROBLEMS

__none

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

_____

VII. GASTROINTESTINAL PROBLEMS

__none

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

__none

a) o Stroke
b) o Dementia or Alzheimer's Disease
c) o Parkinson's Disease
d) o Epilepsy or Seizures
e) o Head injury/concussion
f) o Other, specify: _____

_____

IX. OTHER HEALTH PROBLEMS

__none

a) o Allergies *(specify)*: _____

_____

b) o Anemia

c) o Hernia

d) o Thrombosis (blood clots)

e) o Cancer *(of what)*: _____

_____

f) o Depression

g) o Sexual function problems *(specify)*: _____

_____

h) o Other, specify: _____

_____

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.	

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

NAME OF DRUG	REACTION
1.	
2.	
3.	
4.	

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*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

FAMILY HISTORY

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

- ☐ No ☐ Yes Dementia or Alzheimer's Disease
- ☐ No ☐ Yes Diabetes
- ☐ No ☐ Yes Depression
- ☐ No ☐ Yes Heart disease
- ☐ No ☐ Yes Stroke
- ☐ No ☐ Yes Cancer: _____

CURRENT MEDICAL SYMPTOMS OR PROBLEMS

To be certain that we've covered everything, please check if you have had any of the following symptoms or problems DURING THE LAST 3 MONTHS:

I. GENERAL PROBLEMS

__none

a) o Weight loss
b) o Weight gain
c) o Fevers
d) o Chills
e) o Sweats
f) o Cold or flu
g) o Change in appetite

II. EYE PROBLEMS

__none

a) o Trouble seeing
b) o Eye pain
c) o Dry eyes

III. EARS, NOSE, MOUTH & THROAT PROBLEMS

__none

a) O Trouble hearing
b) O Ear pain or itching
c) O Sinus trouble
d) O Nose bleeds
e) O Sore throat

f) O Teeth problems
g) O Hoarseness
h) O Mouth sores
i) O Allergies

IV. HEART PROBLEMS

__none

a) O Chest pain or tightness
b) O Rapid or irregular heartbeat
c) O Swelling of feet

V. LUNG PROBLEMS

__none

a) O Persistent cough
b) O Coughing up blood
c) O Wheezing
d) O Difficulty breathing or shortness of breath

VI. DIGESTION PROBLEMS

__none

a) O Difficulty swallowing

b) O Frequent indigestion / stomach ache / heartburn
c) O Frequent nausea or vomiting
d) O Change in bowel habits
e) O Black bowel movement or bleeding from rectum
f) O Frequent diarrhea
g) O Persistent constipation

VII. BONE & JOINT PROBLEMS

__none

a) O Leg pain on walking

b) O Back or neck pain
c) O Joint pain or stiffness
d) O Foot problems

e) O Falls

VIII. BRAIN & NERVOUS SYSTEM PROBLEMS

__none

a) O Frequent headaches
b) O Frequent dizzy spells

c) O Passing out or fainting
d) O Problems with sleep

e) O Paralysis, leg or arm weakness
f) O Numbness or loss of feelings
g) O Poor memory or difficulty thinking
h) O Tremor or shaking

IX. MOOD PROBLEMS

__none

a) O Depression
b) O Anxiety
c) O Delusions/hallucinations

X. GYNECOLOGY PROBLEMS

__none

a) O Vaginal bleeding
b) O Vaginal discharge
c) O Breast lumps or discomfort

XI. KIDNEY & URINARY PROBLEMS

__none

a) O Urination at night. # of times: _____
b) O Frequent urination
c) O Painful urination
d) O Difficulty starting or stopping urination
e) O Loss of urine or getting wet. If yes, 6 or more times in last year?

XII. SKIN PROBLEMS

__none

a) O Rash
b) O Sores
c) O Itching

XIII. MISCELLANEOUS PROBLEMS

__none

a) O Excessive thirst
b) O Feel too hot or too cold
a) O Problems with sexual function

HEALTH MAINTENANCE

Have you ever had an examination of your **bowel with a scope**?

❒ No ❒ Yes: when was your most recent (__ sigmoidoscopy/___ colonoscopy)? _____ (year)

Have you had a **hearing test** within the last two years? ❒ No ❒ Yes

Have you had an **eye exam** within the past year? ❒ No ❒ Yes

In the past 12 months, have you had a test for **blood in your stool** *(three cards at home)*?

❒ No ❒ Yes

Have you seen a **dentist** in the last year? ❒ No ❒ Yes

Have you ever had the **Pneumovax vaccine** (a shot to prevent pneumonia)? ❒ No ❒ Yes

If "yes," in what year did you have your last Pneumovax vaccine? _____ (year)

Have you ever had a **tetanus shot**? ❒ No ❒ Yes

If "yes," in what year did you have your last tetanus shot? _____ (year)

Have you had a **flu shot** this season, October-February (not applicable March-September)?

❒ No ❒ Yes

Do you always wear a **seatbelt** when you ride in a car? ❒ No ❒ Yes

Do you currently participate in **regular activity** to improve or maintain your physical fitness?

❒ No ❒ Yes: what activity do you do currently: _____

Do you have any **problems with falling**? ☐ No ☐ Yes

Are you afraid of falling? ☐ No ☐ Yes

Have you had a fall in the past year? ☐ No ☐ Yes

If you had a fall, did you have a problem getting up by yourself? ☐ No ☐ Yes

MEN ONLY:

Have you ever had a **prostate exam** (rectal exam)? ☐ No ☐ Yes

If "yes," when did you have your most recent prostate exam? _____ (year)

Have you ever had a blood test to look for cancer of the prostate (**PSA**)? ☐ No ☐ Yes

If "yes," when did you have this most recent blood test? _____ (year)

WOMEN ONLY:

Do you perform **breast self-exam** (BSE) once a month? ☐ No ☐ Yes

Have you ever had a **mammogram**? ☐ No ☐ Yes: _____ (month/year)

Have you had a **hysterectomy** (surgical removal of the uterus)? ☐ No ☐ Yes

If "no," have you ever had a **Pap smear** / pelvic examination? ☐ No ☐ Yes: _____ (month/year)

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—specify: _____

Which of the following best describes your residence?

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

Are you currently:

o Married (# of previous marriages: ___) o Divorced / Separated o Widowed
o Single / Never married o Living with Significant Other

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

How much **school** did you complete? (where did you attend school? ___US ___abroad)

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
o Postgraduate degree

What has been your principal **occupation**? _____

Are you currently:

o Retired / not working o Working part-time o Working full-time

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

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

Is this sufficient to meet your needs? ☐ No ☐ Yes

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

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

Is this sufficient to meet your needs? ☐ No ☐ Yes

Who would you call if you were sick and needed help?_____

Do you **provide care** for a family member? ☐ No ☐ Yes

Do you **drive** a vehicle? ☐ No ☐ Yes

Do you drink alcohol (such as beer, wine, 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? ☐ No ☐ Yes

Have you ever smoked cigarettes? ☐ No ☐ Yes

If "yes," are you now smoking? ☐ No ☐ Yes

How many years have you smoked? _____ How much do you smoke? _____ packs per day

If "no," how many years ago did you quit? _____ For how many years did you smoke? _____

How much did you smoke? _____ packs per day

PLANNING FOR FUTURE HEALTH CARE

Do you have a medical Durable Power of Attorney? ☐ No ☐ Yes

Do you have a living will? ☐ No ☐ Yes

Please indicate if you need help with any of the following, and if so, who helps you.

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 / finances			
Doing laundry			
Doing housework			
Grocery shopping			
Driving			
Doing "handyman" tasks			
Climbing stairs			
Getting to places beyond walking			

Do you have any other health problems that you would like your doctor to know about before your visit?

☐ No ☐ Yes: _____

_____

_____

_____

COMPLETION OF FORM

THIS FORM MUST BE SIGNED BELOW BY THE PATIENT. NO PROXY SIGNATURES PLEASE.

_____

Print Name

_____ _____

Signature Date

We appreciate your help in completing this form. Thank you.