

ADRC CONTROL SUBJECT APPLICATION

**Information:** **Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First MI

**Address:** \_\_\_\_\_  
Street City State Zip

**Telephone:** (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work

**Year of Birth:** mo: \_\_\_\_\_ yr: \_\_\_\_\_ **Age:** \_\_\_\_\_ **Male:** \_\_\_\_\_ **Female:** \_\_\_\_\_

**Proxy/Contact Person Information:**

**Name:** \_\_\_\_\_  
Last First MI

**Address:** \_\_\_\_\_  
Street City State Zip

**Telephone:** (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Work

How much time do you spend with this person? \_\_\_\_\_

**Primary Physician Information:**

**Name:** \_\_\_\_\_  
Last First MI

**Address:** \_\_\_\_\_  
Street City State Zip

**Telephone:** (\_\_\_\_) \_\_\_\_\_ **FAX:** (\_\_\_\_) \_\_\_\_\_

**Demographic Information:**

Education (Enter in years): \_\_\_\_\_

Major lifetime occupation: \_\_\_\_\_ (see options below)

- 1= Professional      2= Executive      3= Clerical      4= Sales
- 5= Manual Trade    6= Factory      7= Farming      8= Homemaker
- 9= Other            10= Never Worked

Current occupational status: \_\_\_\_\_ (see options below)

- 1= Working            2= Unemployed      3= Retired      4= Permanently Disabled
- 5= Temporarily Disabled    6= Homemaker

Marital Status: \_\_\_\_\_ (see options below)

- 1= Married            2= Widowed      3= Divorced      4= Separated
- 5= Never Married      6= Cohabiting

Present living arrangement: \_\_\_\_\_ (see options below)

- 1= Alone      2= Spouse      3= Other Relative      4= Retirement Community      5= Assisted Living
- 6= Nursing Facility      7= Other (specify) \_\_\_\_\_

Ethnicity: Hispanic/Latino \_\_\_\_\_ 1= Yes      2=No

Race: \_\_\_\_\_ (see options below)

- 1= White      2=African American      3= Asian      4= American Indian      5= Pacific Islander
- 6= Other

Native Language: \_\_\_\_\_ (see options below)

- 1 = English      2 = Other (Specify): \_\_\_\_\_
- Age When Subject Learned English: \_\_\_\_\_

How did you learn about the ADRC? (Check no more than 3)

- |                               |     |                            |     |
|-------------------------------|-----|----------------------------|-----|
| Alzheimer’s disease in Family | ( ) | Research Interest          | ( ) |
| Benedum Geriatric Clinic      | ( ) | Support Group              | ( ) |
| Media                         | ( ) | AOC Satellite Clinic       | ( ) |
| Neurology Clinic              | ( ) | CHS Memory Study           | ( ) |
| Private Practitioner Referral | ( ) | Family Genetics Study      | ( ) |
| Self/ Possible Problems       | ( ) | GEM Study                  | ( ) |
| Family Member Referred        | ( ) | Late Life Depression Study | ( ) |
| Relative in Study             | ( ) | Other: _____               | ( ) |

Are you interested in participating in Research Studies? \_\_\_\_\_ 1= yes      2= No

**Medical Conditions:**

Please indicate whether you have or have had any of the following conditions by checking (✓) Yes or No:

<b>Medical Condition</b>	<b>YES</b>	<b>No</b>
Heart Attack (Myocardial Infarction/"Coronary")		
Parkinson's disease		
Bypass surgery (Coronary artery bypass)		
Congestive heart failure, heart failure Stroke/ brain hemorrhage/ or brain embolism		
TIA (transient ischemic attack) "ministroke"		
Head injury where you lost consciousness, (was "knocked out") <b>If so when?</b> _____ <b>How long were you unconscious?</b> _____		
Open heart surgery		
Brain aneurysm requiring surgical repair		
Brain surgery		
Cancer/Tumor <b>If Yes, Type of Cancer and Year</b> _____		
Diabetes/ "sugar"/ High blood sugar		
Elevated Cholesterol and /or Triglycerides		
Thyroid disease		
Rheumatoid Arthritis or Lupus		
Hearing Impairment?		
Do you wear hearing aides?		
Can you hear well enough to understand spoken instructions?		
Vision Impairment?		
If visually impaired, can you see well enough to perform simple paper and pencil tests?		

Medical Condition	YES	No
High Blood pressure / Hypertension		
Kidney disease or kidney dialysis		
Seizure disorder / epilepsy		
Leukemia or other blood diseases _____		
HIV Human immunodeficiency virus or AIDS		
History of Significant Alcohol Use		
Have you ever been told to quit drinking?		
Or has your drinking ever been a problem for you or your family?		
Do you currently drink alcohol? <b>If so, how much?</b> _____		
History of drug abuse If yes when _____		
Have you ever been given a diagnosis of schizophrenia?		
Have you ever been treated for depression in the past?		
Have you ever received electroconvulsive therapy, ECT (shock treatments)? If so, how many and when (year). _____		
Have you ever been given a diagnosis of Manic/Depression or Bipolar disorder?		
Other medical problems not listed: _____		
If female, are you still menstruating?		

**Medications:**

Please list any **medications, vitamins, or over the counter nutritional products** you are taking. If you are not taking any, please check **None**. (Please include the dose and how often you are taking it.)

*Example: Calcium 500mg once a day*

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None

Have you had a CAT Scan (Computerized Axial Tomography) or MRI (Magnetic Resonance Imaging) Scan of the brain?     **Yes or**  **No**

**If yes, please check which type of scan:**

- MRI, date and location \_\_\_\_\_
- CT scan, date and location \_\_\_\_\_