

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

Please briefly describe below the patient's current symptoms or difficulties:

Memory, Thinking, Behavior, and Functional Information:

Please use the following scale to indicate the answer to each question: (Circle 1, 2, 3 or 4)

1= USUALLY 2= SOMETIMES 3= RARELY 4 = NEVER

Does she/he recognize the faces of family and friends?

1 2 3 4

Does she/he remember the names of family and friends?

1 2 3 4

Does she/he remember her/his address or telephone number?

1 2 3 4

Does she/he remember what day or month it is?

1 2 3 4

Does she/he remember where things are usually kept?

1 2 3 4

Does she/he seem confused?

1 2 3 4

Does she/he make sense in conversation?

1 2 3 4

Is she/he able to write her/his name?

1 2 3 4

Has she/he heard sounds or voices or seen things that no one else can hear or see?

1 2 3 4

Is she/he agitated or aggressive?

1 2 3 4

Is she/he currently depressed?

1 2 3 4

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Please rate her/his ability to perform the following activities, by checking (✓) the appropriate box:

Activity	Able to Do without Assistance	Needs Some Assistance	Unable to Do	Does Not Apply
Using the telephone				
Shopping				
Cooking/food preparation				
Household chores/minor repairs				
Laundry				
Managing medications				
Managing money and handling finances				
Bathing and personal grooming				
Dressing (including selecting clothing)				
Going to the bathroom				
Taking part in activities outside the home				

Medical Conditions:

Please indicate whether the subject has any of the following conditions by checking (✓) Yes or No:

Medical Condition	YES	No
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 the patient lost consciousness, (was "knocked out") If so when? _____ How long was the patient unconscious? _____		

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Medical Condition	YES	No
Open heart surgery		
Brain aneurysm requiring surgical repair		
Brain surgery		
Cancer/Tumor if Yes, Type of Cancer and Year _____		
Diabetes/ "sugar"/ High blood sugar		
Elevated Cholesterol and /or Triglycerides		
Thyroid disease		
Rheumatoid Arthritis or Lupus		
Hearing Impairment?		
Does the patient wear hearing aides?		
Can the patient hear well enough to understand spoken instructions?		
Vision Impairment?		
If visually impaired, can the patient see well enough to perform simple paper and pencil tests?		
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		
Has the patient ever been told to quit drinking?		
Or has the patient's drinking ever been a problem for the patient or family?		
Is the patient currently drinking alcohol? If so, how much? _____		

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Medical Condition	YES	No
History of drug abuse If yes when _____		
Has she/he ever been given a diagnosis of schizophrenia?		
Has she/he been treated for depression in the past?		
Has she/he ever received electroconvulsive therapy, ECT (shock treatments)? If so, how many and when (year). _____		
Has she/he ever been given a diagnosis of Manic/Depression or Bipolar disorder?		
Other medical problems not listed: _____		
If female, is the patient still menstruating?		

Medications:

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

Example: Calcium 500mg once a day

None

Has the patient had a CAT Scan (Computerized Axial Tomography) or MRI (Magnetic Resonance Imaging) Scan of the brain since the onset of their memory problems? **Yes or** **No**

If yes, please check which type of scan:

MRI, date and location _____

CT scan, date and location _____

Has the patient ever had an evaluation for his or her memory or thinking problem? **(Circle) Yes or No**

If yes, where and when? _____

Diagnosis given: _____