

Who referred you to USF Health Alzheimer's Center? _____

Does the patient have a problem with memory? Definitely ___ Questionable ___

In what year were problems with memory first noted? _____

Has the problem gotten worse since then? Yes No
 Rapidly ___ Slowly ___ Don't Know ___

Has the patient ever been evaluated for the problem? Yes No
 When: _____ Where: _____
 By Whom: _____

Did he/she have a physical exam? Yes No
 Results: _____

Did he/she have any laboratory tests? Yes No
 Results: _____

Did he/she ever have a CAT Scan ___ or MRI Scan ___? Yes No
 When: _____ Where: _____
 Results: _____

Were you told that the patient **definitely** has Alzheimer's disease? Yes No
 Were you told that the patient **possibly** has Alzheimer's disease? Yes No
 Were you told that the patient has some other type of memory disorder? Yes No
 If yes, what? _____

Is the patient still able to handle his/her checkbook? Yes No

Is the patient still able to recognize friends? Yes No

Is the patient still able to recognize family? Yes No

Is the patient still able to recognize the caregiver? Yes No

Does the patient still drive? Yes No

Is the patient still able to dress him/herself?
 Alone _____
 Needs some help _____
 Needs total help _____

Has there been any problem with getting to the bathroom on time?
 Never _____
 Occasionally _____
 Frequently/all the time _____

Is the patient still able to carry on a conversation?

Fully _____
Impaired _____
Absent _____

The patient has a history of (check all that apply):

Alcohol or drug abuse _____ Emotional/Psychiatric problems _____
Cancer _____ Head injury _____
Cardiac problems _____ High blood pressure _____
Diabetes _____ Stroke _____

What other medical problems does the patient have? Has he or she had any surgeries?

What medications and supplements is the patient taking now? List all prescribed and over-the-counter. (Continue on back or attach a separate sheet if needed.)

<u>Name</u>	<u>Dosage</u>	<u>How Often</u>	<u>Reason Taken</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the patient have any allergies to medications? If yes, please list below. Yes No

Does the patient have any non-medication allergies? If yes, please list below. Yes No

Has anyone on the patient's side of the family had problems with memory disorders, senility, or Alzheimer's disease? Yes No

What was/is the patient's occupation? _____

What was patient's highest level of education? _____

Does the patient have any of the following problems with mood or behavior? Check all that apply)

- Impatient, cranky, irritable, or resistive to help _____
- Depression, sadness, or crying spells _____
- Abnormal happiness _____
- Sleep problems (too much or too little) _____
- Nervous or worrying _____
- Restlessness, rummaging or pacing _____
- Loss of interest in usual activities _____
- Paranoia or false beliefs _____
- Hallucinations (false visions or voices) _____
- Impulsive or embarrassing behavior _____
- Physical aggression _____
- Changes in appetite, weight, or eating habits _____

Questions for the Caregiver:

What is your goal for this evaluation?

Do you belong to a support group? Yes No

Do you have someone who can give you some relief if you need to go to the doctor, hair dresser, or out to see friends? Yes No

Who	Relationship	How Often	How Long
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What was/is your occupation? _____

Do you feel you need:

- Help with making a diagnosis? Yes No
- Help with managing patient's behavior? Yes No
- Help with handling your own feelings? Yes No
- Other? (Describe in remarks section below) Yes No

Do you need more information about community resources? Yes No

Would you like information about research projects or drug studies at the USF Health Alzheimer's Center? Yes No

Insurance Information:

Please complete all applicable information. This information is necessary to verify your coverage. Some information may be on the back of your card.

Name of patient's primary insurance: _____ Yes No
 Subscriber Name: _____
 Policy number: _____ Group Number: _____
 Effective Date: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone Number: _____

Is the Primary Insurance an HMO or PPO? Yes No
 If so, does the patient need a referral to be seen by a specialist? Yes No

Name of patient's secondary insurance: _____ Yes No
 Subscriber Name: _____
 Policy number: _____ Group Number: _____
 Effective Date: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone Number: _____

Is the Secondary Insurance an HMO or PPO? Yes No
 If so, does the patient need a referral to be seen by a specialist? Yes No

Remarks: Please use this space to provide any other information you think might be helpful in evaluating the patient's memory problem.

Thank you