Memory Disorders Clinic
New Patient Questionnaire

Dear Patient:

We are pleased that you have chosen the USF Health Memory Disorders Clinic. Please be reminded that the clinic is part of the academic program at the University of South Florida's Department of Psychiatry. A faculty member will conduct or participate in your evaluation, and a USF resident doctor, intern, medical student, or fellow may also be present or participate.

Until the Memory Disorders Clinic has determined the degree of your memory impairment, please have a caregiver or immediate family member accompany you for all visits to the Memory Disorders Clinic. Please contact us if this is not possible.

We ask your kindness in completing the enclosed New Patient Packet(s):

☐ MDC Evaluation Questionnaire for your appointment on ________________________________

☐ Adult Neuropsychology History Form for your appointment on ___________________________

This information will furnish us with valuable and important information about you and it will give us a more thorough understanding of your difficulties.

It is important that you complete the enclosed form(s) before your clinic appointment, It requires some time and thought that would otherwise be used for the evaluation, and would thus decrease the amount of time we have to evaluate you.

Please answer all of the questions to the best of your knowledge. If you do not know the answer to a question, write "Don't Know" beside the questions. If the question asks something that does not apply, you may write "N/A". Please feel free to write on the back or in the margins should you wish to make additional comments.

If you do not understand any part of the questionnaire or you need assistance for any reason, please call (813) 974-3100 and select Option 2, and a Memory Disorders Clinic staff member will be able to assist you.

Please bring copies of the following to your evaluation:

- Attached Questionnaire
- List of current medications
- Past medical history
- Previous psychiatric or psychological evaluations, testing, or reports
- Previous treatment progress notes
- EEG, EKG, MRI, CT, or PET Scan reports and films/disks
- Recent lab work

USF Memory Disorders Clinic
Department of Psychiatry & Behavioral Neurosciences
University of South Florida ● 3515 E. Fletcher Avenue ● Tampa, FL 33613
(813) 974-3100 ● Fax (813) 974-3223

Patient Information and History

Who referred patient to the USF Health Memory Disorders Clinic? ______________________

____

Name ____
Last First Middle Initial

Address ____
Number & Street

____
City State Zip Country

Home Phone ________________ Primary? ☐ Yes ☐ No
Cell Phone ________________ Primary? ☐ Yes ☐ No
Work Phone ________________ Primary? ☐ Yes ☐ No

Demographics

Date of Birth ____________ Current Age ______ Gender ☐ Male ☐ Female

Birth Place ____
City State Country

Race ☐ White ☐ Asian or Pacific Islander ☐ Other
☐ Black ☐ Native American ☐ Decline to Respond

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Other ☐ Decline to Respond

Handedness ☐ Right ☐ Left ☐ Ambidextrous

Marital Status ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

Language

Language(s) spoken Primary ______________________________
Additional ______________________________

Education

What is the highest grade the patient has attended? ______________________

What is the highest educational degree the patient has earned?

☐ None ☐ GED ☐ High School Diploma ☐ Junior College Degree

☐ 4-Year College Degree ☐ Master's Degree ☐ Doctorate/Professional Degree

Employment

Is the patient currently employed? ☐ Yes ☐ No

Currently retired? ☐ Yes ☐ No

On disability? ☐ Yes ☐ No

What was the patient's primary occupation throughout life? ___________________________________

What is the patient's primary residence?

☐ Own Home	☐ Own Condo	☐ Other:__________________

Who does the patient live with?

☐ Lives alone	☐ With spouse only	☐ With children only
☐ With spouse and children	☐ Assisted living facility	☐ Other:__________________

What is the patient's annual income level?

☐ Less than $7,000	☐ $7,001-$14,999	☐ $15,000-$24,999
☐ $25,000-$39,999	☐ $40,000 or more	☐ Decline to respond

Patient Health Problems and History

Why is the patient being seen at the MDC? ______________________________

In what year were problems with the patient's memory first noted? ______________________

Does the patient drive a motor vehicle? ☐ Yes ☐ No

If no, when did the patient stop driving? ______________________________

Does the patient have problems with walking or standing? ☐ Yes ☐ No

Has the patient experienced any falls? ☐ Yes ☐ No

If yes, when was the latest fall? ______________________________

Does the patient have a pacemaker? ☐ Yes ☐ No

Does the patient have any history of the following?

Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	High blood pressure of hypertension	☐ Yes	☐ No
Angina	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hysterectomy	☐ Yes	☐ No
Atrial fibrillation	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Blood clot in the leg	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Multiple sclerosis	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No	Parkinson's disease	☐ Yes	☐ No
Cirrhosis of the liver	☐ Yes	☐ No	Oophorectomy (surgical ovary removal)	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Sexually transmitted disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Epilepsy (seizures)	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Syphilis	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stroke or CVA or cerebral hemorrhage	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Transient ischemic attack (TIA)	☐ Yes	☐ No
Heart Attack or MI	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Head injury or loss of consciousness	☐ Yes	☐ No			

Does the patient currently drink alcohol? ☐ Yes ☐ No

If yes, how much and how often?______________________________

Does the patient currently smoke? ☐ Yes ☐ No

If yes, for how long & how much per day?______________________________

Does the patient use illegal (recreational) drugs now? ☐ Yes ☐ No

If yes, which one(s), how much, & how often?______________________________

Has the patient's diet changed over the last 3 months? ☐ Yes ☐ No

If yes, which one(s), how much, & how often?____

Has the patient lost or gained weight in the last 6 months without trying? ☐ Yes ☐ No

If yes, please describe:____

What doctors or other health care providers is the patient currently seeing? Please list:

Doctor/Therapist	Specialty	Phone Number
		( )
		( )
		( )
		( )
		( )

Has the patient had any hospitalizations and/or surgeries? *If you need more space, please write on the back.* ☐ Yes ☐ No

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____

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____

____

Has the patient had a CT/MRI of the Brain within the last year? ☐ Yes ☐ No

Date ____/____/____ Where:____

Date ____/____/____ Where:____

Date ____/____/____ Where:____

Date ____/____/____ Where:____

Who completed this intake packet? ____

Name and relationship to patient

Reminder: Please bring the following to your appointment:

- A list of all prescription & over-the-counter medications, and vitamins or supplements that you are currently taking
- A list of all your doctors whose care you are currently under, including addresses, telephone & fax numbers
- A report and CD/film copy of any brain imaging completed within the last 12 months
- A report/copy of any lab (blood) work completed within the last 3 months

Medication History

Medication History For ____
(patient name)

Pharmacy Name ____________________ Pharmacy Phone Number ______________

Pharmacy Address ____

Allergies/Intolerances

Name (brand or generic)	Reaction (please be specific)

Current Medications

(under response please indicate if medication "worked well", "somewhat worked" or "didn't work at all")

Name (brand or generic)	Dosage	Frequency (times per day and/or time of day)	Date Started	Prescribing Physician	Response to Medication	Side Effects Experienced

Other Medication(s)

(please indicate over-the-counter (OTC) products, herbal products, and vitamins)

Name (brand or generic)	Dosage	Frequency (times per day and/or time of day)	Date Started	Response to Medication	Side Effects Experienced

Previous Medication(s)

(please include ALL previously prescribed medications used for the treatment of any mental health problems you have experienced)

Name (brand or generic)	Dosage	Frequency (times per day and/or time of day)	Date Started	Date Stopped	Response to Medication	Side Effects Experienced

Please provide us with any additional information regarding your past or present experience with medications:

____

____

____

____

____

Name of patient or person completing this form and relationship to patient ____________________

____

Signature ______________________________ Date ____________________

Caregiver Information

Name ____
Last First Middle Initial

Gender ☐ Male ☐ Female Date of Birth ____________

Address ____
Number & Street

____
City State Zip Country

Home Phone ____________________ Primary? ☐ Yes ☐ No
Cell Phone ____________________ Primary? ☐ Yes ☐ No
Work Phone ____________________ Primary? ☐ Yes ☐ No

Email Address __________________________

Race ☐ White ☐ Asian or Pacific Islander ☐ Other
☐ Black ☐ Native American ☐ Decline to Respond

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Other ☐ Decline to Respond

Marital Status ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

Years of Education ______________ Primary Occupation ________________________

Are you currently employed? ☐ Yes ☐ No

Relationship to the Patient ________________________________

Do you live with the patient? ☐ Yes ☐ No

How many hours do you spend with the patient? _____ hours per ☐ day ☐ week ☐ month

Do you help care for the patient? ☐ Yes ☐ No
Who helps? ________________________________

Do you feel you need more help to care for the patient? ☐ Yes ☐ No
In what ways?

Does the patient have Durable Power of Attorney? ☐ Yes ☐ No

Does the patient have a living will? ☐ Yes ☐ No

Who is the Health Care Surrogate? ________________________________

Has the patient been declared Incompetent by the court? ☐ Yes ☐ No

Are you the Legal Guardian? ☐ Yes ☐ No
If applicable, who is the legal guardian? ________________________

How do you manage/cope with stress? ________________________________

Informed Consent
Medical Record Confidentiality Statement

University of South Florida Health Sciences Center
Memory Disorders Clinic

I understand that the records of my evaluation and treatment are private and confidential. I understand that my medical records may be shared with other health care providers at the University of South Florida Health Sciences Center for the purposes of diagnosis, education, research, and supervision. My records shall be made available for auditing by the State of Florida, Department of Elder Affairs or its designee, but my records shall not be released further without my written consent or court order.

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Signature of Caregiver/Health Care Proxy Date

______________________________ ______________________
Signature of Witness Date