Advocate Medical Group
Inspiring medicine. Changing lives.

Patient Name:_____

Date of Birth: _____

MRN: _____

Date of Visit: _____

ADVOCATE MEMORY CENTER

NEW PATIENT INFORMATION QUESTIONNAIRE

Please complete this form before your visit.

Form completed by:_____

What is the reason for today's visit?

_____

_____

What are your goals/hopes for today's visit?

_____

_____

MEMORY AND COGNITION

Have you had changes in your memory, thinking or behavior? Yes _____ No _____

If the patient's family or friends have noticed changes then they should fill out this section of the form.

When were the symptoms first noticed (*month/year*)?_____

What was the first symptom(s)?:_____

Progression has been: Rapid (< 2 months) Gradual (6mos-years) Stepwise

Is there a history of head injury / concussion?: Yes _____ No _____

COGNITIVE

	Never (does not occur)	**Rare (less than monthly)**	**Occasional (every week)**	**Frequent (daily / almost daily)**
Not knowing date / time				
Not knowing where one is				
Change in memory				
Difficulty remembering recent events				
Difficulty with word finding				
Forgetting names				

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COGNITIVE continued

	Never (does not occur)	**Rare** (less than monthly)	**Occasional** (every week)	**Frequent** (daily / almost daily)
Misplacing / losing items				
Repeating stories /questions				
Getting lost in a familiar place				
Difficulty following a conversation or TV program				
Difficulty following instructions				
Difficulty with basic arithmetic				
Poor judgment (dangerous actions, excess spending, etc.)				

BEHAVIOR

	Never (does not occur)	**Rare** (less than monthly)	**Occasional** (every week)	**Frequent** (daily / almost daily)
Delusions (false beliefs such as paranoia or infidelity of a spouse)				
Hallucinations (seeing, hearing, etc. things that aren't there)				
Agitation /Aggression (refusing to cooperate, yelling, hitting)				
Depression / Sadness				
Anxiety / Nervousness (nervous, worried or frightened for no reason)				
Elation / Euphoria (too cheerful or happy for no reason)				
Apathy / Indifference (lack of interest in the world or others)				
Disinhibition (impulsive, socially unacceptable behavior)				
Irritability (moody, gets angry easily)				
Motor behavior (pacing, rummaging, fidgeting, etc.)				
Sleep issues (insomnia, confusing day/night, fighting during sleep)				
Appetite (decrease, increase, change in food preference)				

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DAILY FUNCTIONING

Do you drive? Yes _____ No _____ Never Drove _____

If yes, have you had any tickets or accidents in the last year? Yes _____ No _____

Have any concerns been expressed about your driving? Yes _____ No _____

If you are not driving, when did you stop? _____ Why? _____

(check one in each category / row)

TASK	Independent	Needs Some Assist or Cueing	Needs Much Assistance	Unable to Do	Never did this task
Taking public transportation					
Shopping					
Housekeeping					
Meal preparation					
Handling finances (banking, investing, budgeting)					
Managing money (making change, paying bills)					
Taking Meds					
Using the telephone					
Doing laundry					
Socializing					
Getting dressed					
Bathing or showering					
Grooming (teeth, hair, shaving)					
Toilet hygiene					
Feeding self					

MEDICAL / SURGICAL PROBLEMS

(use back of sheet if necessary)

MEDICAL

Illness **Year it started**

_____

_____

_____

_____

Patient Name:_____ Date of Birth: _____ MRN: _____

SURGICAL

Type of Surgery	**Year**

MEDICATIONS

Current Medications:

Drug Name	**Dosage**	**Times per day**	**Length of use**

Over-the-Counter (Vitamins, supplements, laxatives, pain relievers, allergy medicine, cough medicine, etc.)

Name	**Dosage**	**Times per day**	**Length of use**

Allergies or reactions you have had to any medications:

Drug	**Reaction**	**When**

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REVIEW OF SYMPTOMS

Rate your overall health: very good good fair poor

Only circle recent problems, or check None: ☐

General:
Weight change: Inc / Dec
Fatigue / malaise
Fever / Chills

Pain
Local: (where): _____
Generalized

Skin:
Rash / itching

Eyes:
Wear glasses / contacts
Double vision
Blurred vision
Visual loss
Dry eyes
Cataracts
Glaucoma

Ears:
Hearing loss
Ringing in ears
Dizziness (Vertigo)

Nose, Mouth and Throat:
Hoarseness
Dry mouth
Loss of sense of smell
Loss of sense of taste

Heart:
Chest pain
Fainting
Low blood pressure
High blood pressure
Slow heart rate
Fast heart rate
Irregular heart beat
Cold feet / hands
Leg swelling

Lungs
Shortness of breath
Chronic cough

Gastrointestinal:
Change in appetite
Difficulty swallowing
Stomach pains / heartburn
Nausea/vomiting
Diarrhea
Constipation
Liver disease
Bowel incontinence

Metabolic:
Excess thirst
Heat / cold intolerance
Change in sexual interest:
increased / decreased
Hair loss
Thyroid problems
High cholesterol /lipids

Genital-urinary:
Difficulty urinating
Nighttime urination
Urinary urgency
Urinary incontinence / leakage
Urinary tract infection (recent)
Sexually active: Y/ N/ No Ans
Erectile dysfunction

Hematologic
Anemia
Swollen lymph nodes

Musculoskeletal:
Muscle pain
Joint pain
Back pain
Fibromyalgia / Chronic fatigue
Nighttime muscle cramps

Neurological:
Head injury + loss of consciousness
Headaches
Seizures
Muscle weakness _____
Numbness / tingling _____
Loss of balance
Falls
Slow movements
Tremor
Learning disability or ADHD

Problems with sleep
Insomnia
Tired in the morning
Falling asleep during day
Bedtime:_____
Wake time: _____
Snoring
Stop breathing
Moving during sleep

Psychiatric:
Anxiety (nervousness)
Depression (sadness)
Previous psychiatric
hospitalization: Y / N
Hallucinations
Delusions (e.g., paranoia)
Compulsive behavior
History of suicide attempt: Y / N

Other: _____

_____

_____

_____

_____

_____

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HEALTH HABITS

Do you currently or did you ever smoke? Yes ____ No ____

If yes, how many cigarettes per day? _____ For how many years? _____

If you quit smoking, when? _____

Do you drink wine, beer or liquor? Yes _____ No _____

What and how often? _____

Has anyone ever been concerned about your drinking? Yes _____ No _____

Have you used other drugs / substances? Yes _____ No _____

What and how often? _____

Do you have any regular form of exercise? Yes _____ No _____

What and how often? _____

SOCIAL HISTORY

How much education did you complete? (Please circle)

Less than 8th grade	8th grade	Some high school	High school
Some College	College Graduate	Graduate School	Post-graduate

Marital / Partnership Status:

Married	How long?_____
Domestic partner	How long?_____
Widowed	How long?_____
Divorced/Separated	How long?_____
Single/Never married	
Other_____	

What is / was your Primary Occupation: _____

If retired, for how long? _____

If still working, where? _____ How many hours per week? _____

Other significant past occupations: _____

With whom do you live?_____

(alone, spouse, child, other family, other-not family)

Do you get any help from family or friends in your home? Yes _____ No _____

If yes, please describe: _____

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Are you using any agency or services for help at home? Yes _____ No _____

If yes, please describe: _____

Where do you live? Own home Senior apt._____

Condo Assisted Living_____

Apartment Nursing Home_____

If you live at a care facility, please list contact person there.
Name:_____ Phone:_____

How many children do you have? _____

Are you in regular contact with your children? Yes _____ No _____

Are You a Veteran? Yes _____ No _____

If yes, branch and years of service: _____

Hobbies / Interests:_____

_____

Religious / Spiritual Activities: _____

Other Support Systems: _____

_____

Other History

Are there firearms in your home? Yes _____ No ____

Are there support bars in your shower/bath?: Yes _____ No _____

Have you set up the following documents?

Medical Advanced directives or a living will: Yes _____ No _____

Power of attorney for healthcare: Yes _____ No _____

Power of attorney for property: Yes _____ No _____

Are you comfortable with these documents: Yes _____ No _____

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FAMILY MEDICAL HISTORY

Continue on the back if necessary.

Include any serious medical problems and if anyone in the family had a history of Alzheimer's disease, other types of dementia, ALS or motor neuron disease, stroke, seizures or serious psychiatric illness.

Family Member	**Living?**	**Age now or at death**	**Cause of death**	**List Medical/Neurological/Psychiatric Problems current or in the past (e.g. high blood pressure). Include age of onset if known.**
Mother	Y N			
Father	Y N			
Brothers/Sisters (list):				
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			
Children, Biological only (list):				
	Y N			
	Y N			
	Y N			
	Y N			
	Y N			

Add information about grandparents, aunts/uncles, cousins if necessary: _____

Would you or a partner / family member like to meet with a social worker?

Yes _____ No _____ Unsure _____

If yes or unsure, list any concerns that you might want to discuss with a social worker: _____