Advocate Medical Group
Inspiring medicine. Changing lives.

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

ADVOCATE MEMORY CENTER

RETURN VISIT QUESTIONNAIRE

1. **Please write down questions and issues you want to discuss today with the doctor**

2. **Have there been any new changes in thinking abilities or functioning?**

3. **Have there been any new changes in behavior/mood? (For example: depression, anxiety, irritability, anger, hallucinations, paranoia, etc.)**

4. **List changes or any new prescription medications. Are any refills needed?**

Drug Name	Dosage	Times per day	Is this Med new or changed?

5. **List changes or any new over-the-counter medications or supplements.**

6. **List new medication allergies, medical conditions, hospitalizations or surgeries since your last visit.**

HEALTH HABITS

7. **Have you been smoking?** Yes _____ No _____

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

9. **Have you used other drugs / substances?** Yes _____ No _____

10. **Do you exercise regularly?** Yes _____ No _____

11. **Have you fallen in the last year?** Yes _____ No _____

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

12. List <u>current</u> hobbies or outside activities:

_____

_____

DAILY FUNCTIONING

Are you driving? Yes _____ No _____

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					

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: _____

_____

_____

_____

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

REVIEW OF SYSTEMS

Rate your overall health: very good good fair poor

Please circle any NEW problems you are having since your last visit or check None: ☐

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

Pain
Local: (where): _____
Generalized

Skin:
Rash / itching
Other: _____

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: _____
_____
_____
_____
_____
_____