Ideally, this form is to be completed by a Family Member, or someone who knows the patient well and sees him or her regularly.

Please complete all sections fully and accurately, and bring this form to the appointment. This will allow us the best use of time during the visit itself.

Penn Memory Center

Pre-visit Evaluation

Name of Patient: _____

Name of Person completing this form: _____

Relationship to Patient: _____

Date completed: _____

General Information about the patient

Years of education _____ Patient is ❑ right handed ❑ left handed ❑ both

Occupation (❑ current ❑ prior to retirement) _____

Year retired _____

What are the patient's main problems related to memory, thinking, and behavior?

In what year did the changes above first occur, even though you may not have recognized them at that time? _____

Briefly describe the patient's personality before those changes began (for example, easy to get along with, shy, strong-willed, etc.)

- **Please identify and describe specific problem**

Problem area	Are these problems present?	Year problems began	Description/comments
Memory and Thinking: Forgetfulness; misplacing items; re-asking questions just answered, repeating themselves, etc.	❑Yes ❑No		
Language: Difficulty in wordfinding, mispronouncing words, using wrong words, etc.	❑Yes ❑No		
Orientation: Problems identifying date, time, place; getting lost in familiar surroundings, etc.	❑Yes ❑No		
Movement: Problems with gait (walking) and balance	❑Yes ❑No		
Mood and Behavior: Personality changes; physical or verbal aggression; social withdrawal, etc.	❑Yes ❑No		
Self Care: Decline in personal hygiene or grooming; inappropriate clothing choices; bladder incontinence, etc.	❑Yes ❑No		
Household Management: Decline in routine abilities such as meal preparation; managing money/bill paying; housekeeping, using the phone or remote control, etc.	❑Yes ❑No		

- **Family History**

Please provide the following information for **biological/blood relatives only** of the patient. Please note any with **neurodegenerative disease** (including Alzheimer's disease, fronto-temporal dementia, other types of dementia, Parkinson's diease, ALS (Lou Gehrig's Disease), multiple sclerosis, etc.).

neurodegenerative disease diagnosis, if any

Mother Year of birth _____ ❑ Living ❑ Deceased _____

Father Year of birth _____ ❑ Living ❑ Deceased _____

- **Below, please indicate status of biological Sisters (check ❑S) and Brothers (check ❑B)**

1. ❑S ❑B Year of birth _____ ❑ Living ❑ Deceased _____

2. ❑S ❑B Year of birth _____ ❑ Living ❑ Deceased _____

3. ❑S ❑B Year of birth _____ ❑ Living ❑ Deceased _____

- **Below, please indicate status of biological Daughters (check ❑D) and Sons (check ❑S)**

1. ❑D ❑S Year of birth _____ ❑ Living ❑ Deceased _____

2. ❑D ❑S Year of birth _____ ❑ Living ❑ Deceased _____

3. ❑D ❑S Year of birth _____ ❑ Living ❑ Deceased _____

- Was **brain autopsy** performed on any blood relatives with neurodegenerative diease? ❑Yes ❑No

If yes, list findings _____

- **Medical aspects of the patient:** please indicate all that apply.

Vascular		**Year diagnosed**	**Comments**
High blood pressure	❑Yes ❑No		
High cholesterol or triglycerides	❑Yes ❑No		
Diabetes or high blood sugars	❑Yes ❑No		
Heart attack or heart failure	❑Yes ❑No		
Irregular heartbeat	❑Yes ❑No		
Angina or heart-related chest pains	❑Yes ❑No		
Coronary artery disease	❑Yes ❑No		
Atrial fibrillation or another heart rhythm problem	❑Yes ❑No		
Heart valve disease	❑Yes ❑No		
Heart bypass surgery or a stent	❑Yes ❑No		
Stroke	❑Yes ❑No		
"TIA" or "ministroke"	❑Yes ❑No		
Artery disease in your legs	❑Yes ❑No		
"Deep vein thrombosis (DVT)" or blood clots in your legs	❑Yes ❑No		
Repeated miscarriages with pregnancy	❑Yes ❑No		
Significant overweight or obesity	❑Yes ❑No		
Clinical depression or anxiety disorder where you saw a professional or needed to	❑Yes ❑No		
Other vascular disease (please explain)	❑Yes ❑No		
Other medical problems		**Year diagnosed**	**Comments**
Thyroid problems	❑Yes ❑No		
Head trauma	❑Yes ❑No		
Seizures	❑Yes ❑No		
Weight loss (in the past year)	❑Yes ❑No		
Depression (requiring medication)	❑Yes ❑No		
Psychiatric illness (bipolar disorder, schizophrenia, etc.)	❑Yes ❑No		
Electroconvulsive Therapy (ECT)	❑Yes ❑No		

- **Allergies** ❑ Iodine ❑ Latex ❑ Adhesive Tape ❑ contrast dye ❑ other _____
  ❑ medication allergies _____

- **Hospitalizations:** please list all hospitalizations and surgeries.

Hospital	Date	Reason

- **Medications:** please list everything, including vitamins, aspirin/pain relievers, herbals, etc.

Product name	Strength (i.e. milligrams)	Dosage (times per day)	Reason for this medication
Please attach an additional sheet if necessary to list all medications			

Vascular Risk Assessment

- **Family History**

Have any of your first degree relatives (mother, father, sister, brother) had early heart attacks, strokes, other heart disease, sudden death? (Note: "early" is <55 for men or <65 for women) ❑Yes ❑No

- **Smoking**

Do you currently smoke or have you ever smoked regularly?	❑Yes ❑No
If yes, how many packs per day?	
How old were you when you started?	
If you quit, how old were you when you quit?	
If you still smoke, how many packs per day do you smoke now?	

- **Alcohol**

How much alcohol do you drink currently?

❑None

❑Less than 4 drinks per week

❑5-14 drinks per week

❑More than 14 drinks per week