Penn Memory Center

Pre-Visit Evaluation

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.

Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Information about the Patient**

Patient mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient e-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years of education: ­\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient is: ☐ Right-handed ☐ Left-handed ☐ Both

Occupation: ☐ Current \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Former \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year Retired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Not applicable

Describe the patient’s main problems related to memory, thinking, and behavior.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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In what year did you first notice these changes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the patient’s personality before these changes began. (Examples: easy-going, shy, strong-willed, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please identify and describe specific problems.

|  |  |  |  |
| --- | --- | --- | --- |
| 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 ability to complete routine chores such as meal preparation; managing money/bills; housekeeping; using the phone, etc. | ☐ Yes  ☐ No |  |  |

**Family History**

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

*neurodegenerative disease*

*diagnosis, if applicable*

**Mother** —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father** —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. ☐S ☐B —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. ☐S ☐B —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate status of biological **sons** (check ☐S) and **daughters** (check ☐D)

1. ☐S ☐D —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. ☐S ☐D —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. ☐S ☐D —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. ☐S ☐D —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. ☐S ☐D —Year of Birth: \_\_\_\_\_\_\_\_\_\_\_ ☐ Living ☐ Deceased \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was **brain autopsy** performed on any blood relatives with neurodegenerative disease? ☐Yes ☐No ☐Unknown

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 | ☐ 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 the legs | ☐ Yes  ☐ No |  |  |
| “Deep vain thrombosis (DVT)” or blood clots in the legs | ☐ Yes  ☐ No |  |  |
| Repeated miscarriages with pregnancy | ☐ Yes  ☐ No |  |  |
| Significant overweight or obesity | ☐ Yes  ☐ No |  |  |
| Clinical depression or anxiety disorder requiring professional assistance | ☐ 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 ☐ None

☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Medication Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations**: Please list all hospitalizations and surgeries.

|  |  |  |
| --- | --- | --- |
| Name of Hospital | Date | Reason |
|  |  |  |
|  |  |  |
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|  |  |  |
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**Medications**: Please list everything, including vitamins, over-the-counter medications, herbals, etc. Attach an additional sheet if necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| Product Name | Strength (i.e. milligrams) | Dosage (# of times per day) | Reason for medication |
|  |  |  |  |
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**Vascular Risk Assessment**

**Family History**

Have any of the patient’s 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**

|  |  |
| --- | --- |
| Does the patient currently or has he/she ever smoked regularly? | ☐ Yes ☐ No |
| If he/she did smoke in the past, how many packs per day? |  |
| How old was the patient when he/she started? |  |
| If the patient quit, how old was he or she? |  |
| If the patient still smokes, how many packs per day? |  |

**Alcohol**

How much alcohol does the patient drink currently?

☐ None

☐ Fewer than 4 drinks per week

☐ 5-14 drinks per week

☐ More than 14 drinks per week

**General information about the primary informant/person completing this form:**

First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years of education: ­\_\_\_\_\_\_\_\_\_\_\_\_\_

To your knowledge, does the patient have an advanced directive?

☐ Yes ☐ No ☐ Unsure

To your knowledge, does the patient have a designated Power of Attorney (POA)?

☐ Yes ☐ No ☐ Unsure

If yes, name of POA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of POA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient have a primary caregiver?

☐ Yes ☐ No

If yes, name of caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient need a caregiver?

☐ Yes ☐ No

The Penn Memory Center provides services to those who support our patients. The following statements are for the patient’s primary informant or caregiver to complete. The responses will help us identify programs/services that may be helpful. Please circle the most appropriate response to the following prompts.

1. I have little control over my relative’s illness.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not a problem | Yes, with  no distress | Yes, with  mild distress | Yes, with moderate distress | Yes, with severe distress |

2. I have little control over my relative’s behavior.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not a problem | Yes, with  no distress | Yes, with  mild distress | Yes, with moderate distress | Yes, with severe distress |

3. My relative constantly asks the same questions over and over.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not a problem | Yes, with  no distress | Yes, with  mild distress | Yes, with moderate distress | Yes, with severe distress |

4. I have too many jobs/chores (cooking, shopping, bills) that my relative used to do.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not a problem | Yes, with  no distress | Yes, with  mild distress | Yes, with moderate distress | Yes, with severe distress |

5. I am upset that I cannot communication with my relative.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not a problem | Yes, with  no distress | Yes, with  mild distress | Yes, with moderate distress | Yes, with severe distress |

6. I am totally responsible for keeping the household in order.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not a problem | Yes, with  no distress | Yes, with  mild distress | Yes, with moderate distress | Yes, with severe distress |

7. I feel so alone — as if I have the world on my shoulder.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not a problem | Yes, with  no distress | Yes, with  mild distress | Yes, with moderate distress | Yes, with severe distress |

If not completed, please explain why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Would you find it helpful to talk to one of our dementia specialist counselors?

☐ Yes ☐ No

Please add anything else that may help us better serve your family.

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