Unity Memory Clinic

Patient information Please fill out this form and bring it to your appointment

Name of patient: _____

Last First MI

Male ☐ Female ☐ Date of Birth: _____

Caregiver/Contact Person Information

Name of person completing form: Relationship to patient: _____

Phone number: E-mail address: _____

Primary Care Physician: Referring physician: _____

Patient Demographic Information

What level of education have you completed?

9 years or less ☐
Years:_____
10 years ☐
11 years ☐
High school graduate ☐
GED ☐
Associate's degree ☐
Bachelor' degree ☐
Graduate degree ☐

Did you receive learning support?

Primary school ☐
Secondary school ☐

Major Lifetime occupation:

Professional ☐
Executive ☐
Clerical ☐
Sales ☐
Manual trade ☐
Factory ☐
Homemaker ☐
Never worked ☐

Current Employment Status:

Full time/Part time ☐
Retired ☐
Disabled ☐

Marital Status:

Married ☐
Widowed ☐
Divorced ☐
Separated ☐
Never married ☐
Cohabitating ☐

Present living arrangement:

Alone ☐
With spouse ☐
With other relative ☐
Retirement community ☐
Assisted living facility ☐
Nursing facility ☐

Do you consider yourself:

Right handed ☐
Left handed ☐

Have you ever had neuropsychologic testing?

Do you have a health care proxy?

Why are you seeking an evaluation in our clinic?

In the following section, please check the box next to the problems that you are sure that you have. If you do not have a particular problem, please leave it blank.

Memory troubles		Change in personality		Depression/feeling down	
Speaking problems		Being inappropriate		Anxiety/nervousness	
Knowing the date/time		Disinhibited/overly friendly		Lack of interest in activities	
Writing problems		Change in sex drive		Lack of energy	
Reading problems		Change in food preferences		Hallucinations	
Numbers/calculating		Unaware of other's emotions		Suicidal thoughts	
Concentration		Lack of concern for appearance		Change in sleep pattern	
Planning/organization		Shorter attention span		Change in appetite	
Getting lost		Reduced drive			
Recognizing familiar people		Lacking social graces			
Starting and finishing a project		Distractible			

Please rate your ability to perform the following tasks by checking the appropriate box.

Activity	**Able to do without assistance**	**Needs some assistance**	**Unable to do**
Using the telephone			
Shopping			
Cooking/food preparation			
Household chores/minor repairs			
Laundry			
Managing medications			
Managing money and handling finances			
Bathing and personal grooming			
Dressing (including selecting clothing)			
Bodily Functions (Urination/BM)			
Taking part in activities outside the home			

Please indicate whether you have had any of the following by checking “Yes” or “No”.

	Yes	No
Have you ever had a hallucination (see or hear things others don’t)?		
Do you have violent dreams that you act out in your sleep?		
Are there times when your flow of ideas seems disorganized, unclear or not logical?		
Are you drowsy during the day despite getting enough sleep at night?		
Do you stare off into space for long periods of time?		

Medical Conditions:

Please indicate whether you have had any of the following conditions by checking “Yes” or “No”.

Medical Condition	Yes	No
Stroke		
Mini-Stroke or “TIA”		
Bleeding or hemorrhage in the brain		
Head injury/concussion		
Heart disease/heart attack		
Parkinson’s disease		
Seizure		
Diabetes or prediabetes		
Elevated cholesterol		
High blood pressure		
Depression		
Anxiety		
Bipolar disorder		
Thyroid problem		

ADD/ADHD		
Learning disability		

Please enter any other medical problems or surgeries here:

Tobacco Use:

Current everyday ☐ Current some days ☐ Never ☐ Former smoker ☐ (Year quit_____)

Do you drink alcohol or did you ever drink alcohol?_____

If so, how much?_____

Have you ever had a problem with alcohol or been told you drink too much?_____

Have you ever used recreational or illicit drugs?_____

If yes, please describe:

Family Medical Problems

Please complete the following section regarding health problems of family members

	Alive?		Current Age/ Longevity	Major health problems and/or cause of death
	Yes	No		
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Mother				
Father				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Other				

Do or did any of your family members have memory loss, dementia, Alzheimer's disease or Parkinson's disease?

Known drug allergies and reactions:

Medications:

	Name	Dosage	When/how often taken	When started	Who prescribes
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

Pharmacy Name:_____ Location:_____

Review of systems: Please circle if you are currently having any of these problems

General:	Weight loss/gain	Appetite change	Fevers/chills	Other:
Head/Eyes:	Headache	Loss of vision	Blurred/double vision	Other:
Ears/Nose/Throat:	Hearing change	Drainage	Pain	Other:
Heart:	Chest pain	Heart palpitations	Fainting	Other:
Lung:	Shortness of breath	Wheezing	Cough	Other:
Gastrointestinal:	Stomach pain/nausea	Constipation	Heartburn	Other:
Urinary:	Leakage of urine	Difficulty starting or stopping urine	Frequent waking at night to urinate	Other:
Musculoskeletal:	Joint pain	Neck/back pain	Muscle cramps	Other:
Endocrine:	Excessive sweating	Dry mouth	Excessive thirst	Other:
Skin:	Rash	Bruises	Moles/lumps	Other:
Genital/sexual (men):	Erectile dysfunction	Loss of interest in sex		Other:
Genital/sexual (women):	Change in menstrual cycle	Loss of interest in sex	Pain with sex	Other:

Signature and Date of person completing form:_____

Doctor Signature/Date:_____