For 1st Memory Visit - Dr. Chalfin's Memory & Thinking Questionnaire

Sometimes when people have changes to their thinking or memory, the people around them notice changes better than they can. Please have a **reliable loved one** (friend, family member, or caregiver) fill out this form **about you**.

SOMEONE BESIDES THE PATIENT SHOULD FILL THIS OUT

Patient's Name _____

Person **Answering** Form _____ Relationship _____

Do you live with the patient? **Y | N** How many days/wk do you have contact? **<1 | 1 | 2 | 3-4 | 5+**

Compared with 10 years ago how is the patient at:

	Better, or No Change	A **bit** worse	**Much** worse
1. Remembering birthdays, addresses, occupations of family/friends	0	1	2
2. Recognizing family members, friends, neighbors	0	1	2
3. Remembering recent events	0	1	2
4. Speaking and understanding others	0	1	2
5. Recalling conversations a few days later	0	1	2
6. Remembering his/her own address and telephone number	0	1	2
7. Remembering what day and month it is, appointments	0	1	2
8. Remembering where things are usually kept	0	1	2
9. Remembering where to find things which have been put in a different place from usual	0	1	2
10. Navigating around the neighborhood, community	0	1	2
11. Finding their way around new places	0	1	2
12. Knowing how to work familiar machines around the house	0	1	2
13. Learning to use a new gadget or machine around the house (computer, microwave, remote control)	0	1	2
14. Learning new things in general	0	1	2
15. Cooking/preparing a meal	0	1	2
16. Doing housework (cleaning, laundry, minor repairs)	0	1	2
17. Personal care/cleanliness (brushing teeth, combing hair, shaving, changing clothes)	0	1	2
18. Following a story in a book or on TV	0	1	2
19. Making decisions on daily matters; having good judgment	0	1	2
20. Handling money for shopping	0	1	2
21. Balancing a checkbook, paying bills, doing income taxes	0	1	2

	Better, or No Change	A **bit** worse	**Much** worse
22. Using his/her intelligence to solve a problem	0	1	2
23. Having daily problems with thinking or memory	0	1	2
24. Repeating the same thing or question repeatedly	0	1	2

Total Score: _____ (Range: 0-48)

Check all of the following activities which the patient can do completely independently, start to finish, without any assistance or supervision:

- ☐ Bathing/showering
- ☐ Dressing
- ☐ Using the toilet, wiping, etc.
- ☐ Getting in/out of bed or chair
- ☐ Bladder and bowel control
- ☐ Feeding self

Has the patient had any of the following changes or issues?

Yes	No	
☐	☐	Uncontrolled depression or anxiety, irritability, or agitation
☐	☐	Physical or verbal aggression or resistance of care from others
☐	☐	Decreased interest in activities
☐	☐	Impulsivity, disinhibition, doing or saying inappropriate things
☐	☐	Cravings or habits they overdo (for example, gambling, spending, overeating, sex, etc)
☐	☐	Hallucinations (Seeing, hearing, or feeling things others do not)
☐	☐	Paranoia or Suspicion (for example, believing someone is stealing or harming them)
☐	☐	Trouble sleeping at night
☐	☐	Acting out dreams at night (kicking, punching, yelling, falling out of bed)
☐	☐	Snoring loudly or stopping breathing during sleep
☐	☐	Difficulty staying awake during the day/during activities
☐	☐	Staring spells or seizures
☐	☐	Severe fluctuation in mental status
☐	☐	Balance issues/Unsteadiness? - If yes, how many falls in the past 6 months? _____
☐	☐	Tremor, shaking, or difficulty moving a body part

SAFETY ASSESSMENT

- Does the patient drive? **Y** | N | If no, when did they stop driving? _____ | Why? _____
  - In the past year, have they had fender benders, dents, or accidents? **Y** | N | How many? ___
  - In the past year, have they had traffic tickets or been pulled over? **Y** | N | How many? ____
  - Have they gotten lost while driving? **Y** | N
  - Have they limited their driving (e.g., avoiding highways, nights, unfamiliar areas)? **Y** | N
- Does the patient live alone? **Y** | N
- Are there concerns about safety in the home? **Y** | N
- Does the patient need more help and supervision? **Y** | N
- Are there any firearms/guns at home? **Y** | N | Are they unlocked? **Y** | N | Kept loaded? **Y** | N
- Has the patient gotten lost in a familiar place (not while driving)? **Y** | N

- Are you concerned about the patient and any of the following?
  - ☐ Driving
  - ☐ Paying bills
  - ☐ Organizing paperwork
  - ☐ Shopping for groceries or household items
  - ☐ Managing money
  - ☐ Cooking, preparing meals, heating water
  - ☐ Keeping things clean or taking care of housework
  - ☐ Keeping track of their own medical care
  - ☐ Taking the right medications everyday
  - ☐ Wandering or Getting lost
  - ☐ Safety at home
  - ☐ Vision / Hearing

Caregiver Profile

1. Do you understand what Alzheimer's and/or other dementias are? **Y** | N
2. Do you know where you can obtain additional information about the disease? **Y** | N
3. Are you able and willing to provide care or assistance? **Y** | N
4. Do you know where you can receive support as a caregiver? **Y** | N

GIVE THIS PAGE TO PATIENT TO FILL OUT THEMSELVES

Are you currently satisfied with your sleep? Y | **N** | If not, why not? _____
Are you tired or sleepy during the day? **Y** | N

Over the last 2 weeks, how often have you felt:

	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things				
Down, depressed, or hopeless				

Do you currently take any of the following medications, even occasionally?

Yes	No	
☐	☐	Sleep Aids such as Tylenol PM, Zzzquil, or Unisom
☐	☐	Ambien (Zolpidem), Lunesta, or Sonata
☐	☐	Sleep/Anxiety Meds: Xanax (alprazolam), Ativan (lorazepam), Valium (diazepam), Klonopin (clonazepam), or Restoril (temazepam)
		Other Sleep Aid: _____
☐	☐	Antihistamines such as Benadryl (Diphenhydramine)
☐	☐	IBS Meds such as Dicyclomine (Bentyl) or hyoscyamine
☐	☐	Oxybutynin (Ditropan) or Tolterodine (Detrol) (used for overactive bladder, sweating)
☐	☐	Muscle relaxers such as cyclobenzaprine (Flexeril) or methocarbamol (Robaxin)
☐	☐	Pain meds/Narcotics such as tramadol, hydrocodone, or oxycodone

- Who do you want to make medical decisions on your behalf if you are unable? _____
  What about financial decisions? _____
- Do you have a formal advanced directive (living will)?_____
- Do you have any wishes for your care that you would like to share here?
  - ☐ Do not Resuscitate (DNR)
  - ☐ Do not Intubate (DNI)
  - ☐ No Feeding Tubes
  - ☐ No Hospitals
  - ☐ No Invasive Tests
  - ☐ No Surgeries
  - ☐ Something else _____