KAISER PERMANENTE®

Diablo Service Area Memory Center

Required Pre-Visit Questionnaire

Date _____

This questionnaire is to be filled out by someone who knows the patient well.

Thank you for completing and submitting this questionnaire **prior to your appointment**. The answers are important to help us understand your level of functioning and to know your concerns **ahead of time**, so that we will be able to address your specific needs at the appointment.

After watching the required online Memory Orientation Class, are you still interested in having a memory evaluation?

No – Please call us at 925-313-4577 to cancel your appointment
Yes – Please complete this questionnaire to the best of your ability

During the appointment, will patient require an interpreter?..... ☐Yes ☐No

If yes, language preferred _____

Who viewed the class online? Patient?..... ☐Yes ☐No

Anyone else? _____

1 Demographics, Medical, and Functional Information

1. Patient Name _____
2. Medical Record Number _____
3. Date of Birth _____
4. Contact person for appointment, relationship to patient, and phone number

_____

5. Does patient have an Advance Directive and or Power of Attorney?
   a) for health care ..... ☐Yes ☐No
   b) for finances..... ☐Yes ☐No

7.Living situation:

☐Home alone? ☐Home with family?

☐Paid caregiver? Hours per day _____ or Hours per week _____

☐Board and Care? ☐Nursing Home? ☐Assisted Living Facility?

Name and contact information of facility:

_____

8. Patient's highest level of education _____

9. Previous occupation _____ Years retired _____

OR

Current Occupation _____

2 Income Sources: Please check all that apply

☐Social Security ☐Pension ☐Investments ☐Savings

☐Long term care insurance ☐VA ☐Currently employed

Does the patient have Medi-Cal ..... ☐Yes ☐No

3 When did memory problems start? _____

First things noticed:

_____

4 Are you a Veteran? ..... ☐Yes ☐No

1. Did you or your spouse serve during an active war?..... ☐Yes ☐No

   If yes, which war?

2. Did you or your spouse receive any medals of honor?..... ☐Yes ☐No

   If yes, please list the medals of honor received:

5 Stressors:

1. Recent hospitalization ..... ☐Yes ☐No
2. Recent move ..... ☐Yes ☐No
3. Recent death in the family..... ☐Yes ☐No
4. Other stressors..... ☐Yes ☐No

   If yes, please explain other stressors

6 Does the patient have any history of the following?

1. Depression: Seems sad or says that he or she is depressed?..... ☐Yes ☐No

   If yes, please describe the severity of the depression:

_____

2. History of suicide attempts? ..... ☐Yes ☐No

If yes, how many times and timeframe (list year) of the attempt?

3. Anxiety: Becomes upset when separated from you or other signs of nervousness such as constant worry, unable to relax or feeling excessively tense?. ..... ☐Yes ☐No
   Is there a specific time of day or incident when the anxiety occurs? ..... ☐Yes ☐No
   If yes, please describe:

4. History of psychiatric problems? ..... ☐Yes ☐No
   If yes, please list diagnosis and or description of psychiatric issues:

5. History of alcohol, marijuana, and or other drug abuse? ..... ☐Yes ☐No
   If yes, please list substance abused:

7 Memory and Cognitive Information

1. Was the onset of memory problems ☐gradual or ☐abrupt?
2. Were there any significant life changes at that time? ..... ☐Yes ☐No
   If yes, please explain:

3. Does the patient forget conversations? ..... ☐Yes ☐No
4. Does the patient repeat statements or questions frequently? ..... ☐Yes ☐No
5. Does the patient forget names of familiar people? ..... ☐Yes ☐No
6. Does the patient fail to recognize family members or friends? ..... ☐Yes ☐No
7. Does the patient lose or misplace things frequently? ..... ☐Yes ☐No

8 Language

1. Does the patient have word finding problems? ..... ☐Yes ☐No
2. Does the patient have difficulty following train of thought? ..... ☐Yes ☐No

3. Do others have difficulty understanding the patient? ..... ☐Yes ☐No

9 Orientation

1. Does the patient act lost or confused in familiar places? ..... ☐Yes ☐No
2. Does the patient need directions to familiar places? ..... ☐Yes ☐No

10 Activities of Daily Living

1. Has the patient's ability to care for the home declined? ..... ☐Yes ☐No
2. Has there been a loss of ability to operate a telephone, computer, TV remote control, or stove? ..... ☐Yes ☐No

11 Personal Hygiene and Dressing

1. Has the patient's ability to care for personal hygiene declined? ..... ☐Yes ☐No

   (for example a decline in bathing frequency, change in ability to fix hair, or shave)
2. Does the patient need reminding to change from dirty clothes? ..... ☐Yes ☐No

12 Control of Urine and Bowels

1. Has the patient had recurrent loss of control of urine? ..... ☐Yes ☐No
2. Has the patient had recurrent loss of control of bowels? ..... ☐Yes ☐No

   If yes, is the patient wearing Depends, pads or diapers? ..... ☐Yes ☐No

13 Meal Preparation

1. Is the patient able to shop for food independently? ..... ☐Yes ☐No
2. Is the patient able to plan and prepare their own meals? ..... ☐Yes ☐No

   If yes, has a family member regularly checked the patient's refrigerator? ... ☐Yes ☐No
3. Is there enough food in the refrigerator? ..... ☐Yes ☐No
4. Is there any spoiled food in the refrigerator? ..... ☐Yes ☐No
5. Has the patient burned food when cooking due to forgetfulness? ..... ☐Yes ☐No

14 Driving

1. Does the patient have a driver's license? ..... ☐Yes ☐No
2. Is the patient driving? ..... ☐Yes ☐No
3. Has the patient gotten lost or confused when driving? ..... ☐Yes ☐No

4. Has the patient had recent tickets when driving? ..... ☐Yes ☐No
5. Does the patient's car have unexplained dents or scratches? ..... ☐Yes ☐No
6. Has the patient had any accidents while driving? ..... ☐Yes ☐No
7. Does anyone have concerns about the patient's driving ability? ..... ☐Yes ☐No
8. Does anyone refuse to ride in a car while the patient is driving? ..... ☐Yes ☐No

15 Medication Management

1. Is the patient responsible for refilling his or her own medications? ..... ☐Yes ☐No
2. Does the patient know what the medications are for? ..... ☐Yes ☐No
3. Does the patient forget to take doses of the medication? ..... ☐Yes ☐No

   If yes, what percentage of the time?

4. Do you help the patient with medication management? ..... ☐Yes ☐No

   If yes, please explain:

16 Finances

1. Does the patient manage financial matters independently? ..... ☐Yes ☐No

   (For example keeps a budget, writes checks, pays bills, keeps track of income and expenditures, makes day-to-day purchases)
2. Are you concerned about the patient's ability to handle money? ..... ☐Yes ☐No
3. Does the patient appear confused by financial information such as bills, banks statements, etc.? ..... ☐Yes ☐No
4. Does the patient regularly miss bill payments? ..... ☐Yes ☐No
5. Does the patient make double payments on bills due to forgetfulness? ..... ☐Yes ☐No
6. Has the patient donated to charities inappropriately? ..... ☐Yes ☐No

   (For example multiple payments in one month, paying more than budget allows)
7. Has the patient given money away inappropriately? ..... ☐Yes ☐No

If yes, please give examples:

8. Has the patient mistaken advertisements or solicitations for bills? ☐Yes ☐No
9. Has the patient been a victim of a financial scam or been taken advantage of financially? ☐Yes ☐No

   If yes, please explain:

17 Sleep

1. Does the patient take medication for sleep? ☐Yes ☐No

   If yes, name of medication:

2. Is the patient up at night or wander? ☐Yes ☐No
3. Does the patient rummage through belongings at night? ☐Yes ☐No
4. Does the patient have active dreaming or is restless during sleep? ☐Yes ☐No
5. Does the patient act out dreams or hit or kick during sleep? ☐Yes ☐No
6. Has the patient been diagnosed with sleep apnea? ☐Yes ☐No

   If yes, does the patient regularly use a C-PAP machine? ☐Yes ☐No

18 Behavior

1. Does the patient deny a significant memory problem? ☐Yes ☐No
2. Does the patient have a change in judgment? ☐Yes ☐No
3. Does the patient have a change in personality? ☐Yes ☐No
4. Does the patient show inappropriate behavior in public? ☐Yes ☐No
5. Does the patient have significant change in food habits, such as eating excessive sweets? ☐Yes ☐No
6. Does the patient show agitation, anxiety or restlessness? ☐Yes ☐No

   If yes, does this occur at a particular time of day or in a particular situation? ☐Yes ☐No
7. Does the patient show a loss of interest in people or activities? ☐Yes ☐No

If yes to any of the above, please explain:

19 Hallucinations (different than delusions)

1. Does the patient see or hear things that are not real? ..... ☐Yes ☐No

   If yes, please give examples:

   If yes, when did they first start?

   If yes, at what time of day do the hallucinations occur?

   If yes, are the hallucinations disturbing to the patient?..... ☐Yes ☐No

Comments

20 Delusions

1. Does the patient believe things have happened that have not? ..... ☐Yes ☐No

   If yes, give examples (such as paranoia, suspiciousness, false accusations, says things have happened that have not)?

   If yes, when did they first start?

   If yes, what time of day?

21 Additional Medical History

1. Has the patient lost weight recently?..... ☐Yes ☐No

   How much? _____

   Since when? _____

2. Does the patient frequently experience dizziness? ..... ☐Yes ☐No
3. Does the patient have trouble with walking or with balance? ..... ☐Yes ☐No
4. Has the patient fallen recently? ..... ☐Yes ☐No
5. Does the patient use a cane or walker? ..... ☐Yes ☐No
6. Does the patient have a significant vision problem? ..... ☐Yes ☐No
7. Does the patient have a significant hearing problem? ..... ☐Yes ☐No
8. Does the patient have a tremor or shaking? ..... ☐Yes ☐No

22 Habits

1. Does the patient smoke cigarettes? ..... ☐Yes ☐No

   If yes, how many packs per day? _____
2. Or smoked in the past? ..... ☐Yes ☐No
3. Does the patient use alcohol? ..... ☐Yes ☐No

   If yes, how many drinks per week? _____
4. Did the patient drink heavily in the past? ..... ☐Yes ☐No

   If yes, how much and how many years? _____

23 Family Medical History

1. Has anyone in the patient's family had significant memory loss? ..... ☐Yes ☐No

   If yes, who and age of onset?

Comments

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.