KAISER PERMANENTE®
Department of Geriatric Medicine

Member:_____
MRN: _____

Pre-Visit Questionnaire for Dementia Evaluation

This questionnaire is to be filled out by someone who knows you well.
Name of Person Completing this Form: _____ Relationship to Patient: _____
How often do you see the patient? _____ Tel #: (_____) _____ — _____

Thank you for having this form completed before your visit. It will allow your doctor to perform the most complete evaluation possible when you arrive for your appointment. Your time and effort is much appreciated.

Referral Data

What is (are) the main reason(s) for bringing the patient to the office? (check all that apply):

☐ Suspected Alzheimer's disease or other dementia

☐ Second opinion on pre-existing AD or other dementia

☐ Other: _____

Neuropsychological Symptoms

Memory

1. How long ago were memory problems first noted? _____ years, _____ months ago
2. What did you first notice or what concerned you?_____

_____

3. Changes in memory were: ☐ Gradual ☐ Abrupt
4. Over the last 6 months, memory is: ☐ Worsening ☐ Staying the same ☐ Getting better

*In the **last 3 months**, have you noticed any of the following?*

	Frequently	Sometimes	Does not Apply
Problems with recent memory	☐	☐	☐
Difficulty remembering a short list of items, e.g. shopping list	☐	☐	☐
Repeating statements, questions, or stories	☐	☐	☐
Tend to live in the past	☐	☐	☐
Misplaced, lost, or hidden objects	☐	☐	☐
Getting lost around the neighborhood	☐	☐	☐
Missed appointments or shown up on the wrong day/time	☐	☐	☐
Difficulty remembering taking medications	☐	☐	☐
Decreased recognition of family or close friends	☐	☐	☐
Problems remembering important events or occasions	☐	☐	☐
Burned pots or pans on the stove	☐	☐	☐
Difficulty learning how to use a tool or gadget	☐	☐	☐

Comments _____

_____

_____

Language/Speech

1. How long ago were language or speech problems first noted? _____ years, _____ months ago
2. What did you first notice or what concerned you?_____

_____

3. Changes in language were: ☐ Gradual ☐ Abrupt
4. Since the problems began, they are: ☐ Worsening ☐ Staying the same ☐ Getting better

*In the **last 3 months**, have you noticed any of the following?*

	Frequently	Sometimes	Does not Apply
Difficulty recalling words	☐	☐	☐
Using the wrong word	☐	☐	☐
Frequently describing an object rather than stating what it is	☐	☐	☐
Difficulty following or understanding conversation	☐	☐	☐
Pauses or hesitation in speech	☐	☐	☐

Comments _____

_____

_____

Judgment/Reasoning

1. How long ago were judgment or reasoning problems first noted? _____ years, _____ months ago
2. What did you first notice or what concerned you?_____

_____

3. Changes in judgment or reasoning were: ☐ Gradual ☐ Abrupt
4. Since the problems began, they are: ☐ Worsening ☐ Staying the same ☐ Getting better

*In the **last 3 months**, have you noticed any of the following?*

	Frequently	Sometimes	Does not Apply
Less clear or less sharp than before	☐	☐	☐
Problem reading written materials and discussing contents	☐	☐	☐
Recognizing an emergency situation and acting appropriately, e.g. small fire in the kitchen	☐	☐	☐
Problems with decision making	☐	☐	☐

Comments _____

_____

_____

Mood/Personality/Behavior

*In the **last 1 month**, have you noticed any of the following?*

	Frequently	Sometimes	Does not Apply
Personality change	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐
Socially withdrawn	☐	☐	☐
Less interest in doing things, hobbies, or activities	☐	☐	☐
Staring off into space	☐	☐	☐
Irritable or easily frustrated	☐	☐	☐
Rapid changes in mood	☐	☐	☐
Stressed out	☐	☐	☐
More stubborn, agitated, aggressive, or resistive to help	☐	☐	☐
Acting impulsively without consideration of consequences	☐	☐	☐
Believing others are stealing from him/her or planning to harm him/her	☐	☐	☐
Delusions/false beliefs, i.e. believing that things that have happened haven't	☐	☐	☐
Hearing voices, seeing things, talking to people who are not there	☐	☐	☐
Falling asleep, staying asleep, or sleeping too much	☐	☐	☐
Feeling anxious, nervous, tense, or fearful	☐	☐	☐
Following or "shadowing" caregiver	☐	☐	☐
Hiding or hoarding things	☐	☐	☐
Hyperactivity/restlessness, e.g. can't sit still, paces, wrings hands	☐	☐	☐
Inappropriate behavior in public	☐	☐	☐
Wandering	☐	☐	☐

Comments _____

_____

_____

Assessment of Stressors

*Have any of the following occurred during the **past year**?*

	Yes	No
Change in living situation	☐	☐
Change in financial situation	☐	☐
Marriage	☐	☐
Change in health of family member	☐	☐

Comments _____

_____

_____

Functional Abilities

Task		Patient Needs Help?		Totally Dependent	Never Did	If Help Needed, Who Helps?
	Needs NO assistance or supervision	Has difficulty but does by self	Needs Assistance or Supervision	Cannot Do at All	Baseline	
Feeding self	☐	☐	☐	☐	☐	
Continence(control bowel and bladder completely)	☐	☐	☐	☐	☐	
Getting to toilet	☐	☐	☐	☐	☐	
Getting dressed	☐	☐	☐	☐	☐	
Bathing or showering	☐	☐	☐	☐	☐	
Walking across the room (includes using cane or walker)	☐	☐	☐	☐	☐	
Writing checks, paying bills, or keeping financial records	☐	☐	☐	☐	☐	
Assembling tax records, business affairs, or papers	☐	☐	☐	☐	☐	
Shopping alone for clothes, household necessities, or groceries	☐	☐	☐	☐	☐	
Playing a game of skill or working on a hobby	☐	☐	☐	☐	☐	
Heating water, making a cup of coffee, or turning off the stove	☐	☐	☐	☐	☐	
Preparing a balanced meal	☐	☐	☐	☐	☐	
Keeping track of current events	☐	☐	☐	☐	☐	
Paying attention to, understanding, or discussing a TV program, book, or magazine	☐	☐	☐	☐	☐	
Remembering appointments, family occasions, holidays, or medications	☐	☐	☐	☐	☐	
Traveling out of the neighborhood, driving, or arranging to take buses	☐	☐	☐	☐	☐	

Social Function

Activities/Interests

Select the activities in which the patient regularly participates:
☐ Gardening ☐ Exercise ☐ Shopping ☐ Cooking ☐ Card Club ☐ Dining out
☐ Reading ☐ Pets ☐ Dancing ☐ Travel ☐ Music ☐ Church
☐ Others: _____

Driving:
Is the patient driving at this time? ☐ Yes ☐ No, stopped driving ☐ No, never drove
If driving, do you have concerns about his/her driving? ☐ Yes ☐ No
If stopped driving, in what year did the patient stop driving? _____ Still has driver's license? ☐ Yes ☐ No

Safety:
Does patient own any firearms/hunting knives? ☐ Yes ☐ No Are there firearms in the home? ☐ Yes ☐ No
Any history of wandering or getting lost while outside the home? ☐ Yes ☐ No
Any history of falls? ☐ Yes ☐ No Is the patient afraid of falling? ☐ Yes ☐ No When was the last fall? ____

Head Trauma
Any history of head injury with loss of consciousness? ☐ Yes ☐ No If so, when? _____
Has patient participated in any activities associated with likelihood of blows to the head? ☐ Yes ☐ No
e.g. boxing, football, ice or roller hockey, soccer, baseball, basketball, and snow skiing

Alcohol
How much alcohol does the patient drink? _____ What type of alcohol (wine, vodka, etc.)? _____

Past Psychiatric History

☐ Anxiety ☐ Bipolar Disorder ☐ Depression
☐ Drug Dependence: _____ ☐ Schizophrenia ☐ Other psychiatric disorders
_____ _____

1. Past psychiatric hospitalizations: _____
2. Outpatient therapy: _____
3. Prior psychiatric medications (and their indications): _____

_____

4. History of suicidal attempt? ☐ Yes ☐ No When? _____
5. History of abuse or trauma? ☐ Emotional ☐ Physical ☐ Sexual

Comments: _____

6. *Substance Use History (e.g. alcohol, marijuana, cocaine, etc.)*
   a. Past substances used (more than 12 months ago): _____
   b. Current substances used: _____

Current Medications

Please review the medication list given to the patient and compare it to the medications that the patient actually takes at home. Make any corrections if needed. Please add any other medications, including herbal/alternative medications, multi-vitamins, or any other over-the-counter medications being taken:

Name	Dosage	How Often?

Family History

Does the patient have any family members with any of the following conditions?

Condition	Which Family Member?	Age of Onset
☐ Dementia, Alzheimer's Disease		
☐ Heart Disease		
☐ Stroke		
☐ Parkinson's Disease		
☐ Depression		
☐ Cancer		

Other medical or psychiatric problems that run in the family: _____

Social History

City/state and country where patient was born: _____

City/state and country where patient was raised: _____

Native Language: _____ Needs an interpreter? ☐ Yes ☐ No

Education

☐ Less than 8th grade ☐ Some high school, grade level: _____ ☐ High school graduate
☐ Some college ☐ College graduate, Degree: _____ ☐ Graduate school, Degree: _____

Work Status

☐ Retired? When? ____ ☐ Working part-time ☐ Working full-time
List principal occupation and other prior significant past occupations: _____

_____

Marital Status

☐ Never married ☐ Married; How many years? _____ ☐ Separated
☐ Divorced ☐ Widowed; How many years? _____ ☐ Living with significant other
How many children does the patient have? _____
Are they in regular contact with the patient? ☐ Yes ☐ No

Living Arrangements

☐ Single-family house ☐ Condo ☐ Apartment ☐ Board and care/assisted living: _____
☐ Nursing home ☐ Other (specify): _____

How many years at present location? _____

Check any of the following individuals that are living in the home with the patient:
☐ Spouse /Partner ☐ Son ☐ Son-in-law ☐ Daughter
☐ Daughter-in-law ☐ Other relatives ☐ Friend ☐ Other: _____

Is there someone helping the patient in the home? ☐ Yes ☐ No
If yes, name and relationship to patient? _____ _____How many hours per day and per week? _____
Is this sufficient to meet the patient needs? ☐ Yes ☐ No

Is the patient a veteran or widow of a veteran? ☐ Yes ☐ No Any financial concerns? ☐ Yes ☐ No
Does the patient have long-term care insurance? ☐ Yes ☐ No

Who should be called if patient is sick and needs help? Please place an asterisk (*) next to the name of the person who is designated to be the health care representative or durable power of attorney for healthcare.

Name	Relationship	Phone Number
_____	_____	(____) ____ – _____
_____	_____	(____) ____ – _____
_____	_____	(____) ____ – _____

Do we have permission to speak to the person(s) listed above on the patient's behalf? ☐ Yes ☐ No

Planning for Future Health Care

Does patient have a Health Care Representative/Durable Power of Attorney for Healthcare? ☐ Yes ☐ No
Advanced Directives, POLST, or Living Will Completed? ☐ Yes ☐ No
If yes, please submit a copy with this form.