Dementia Questionnaire:

If you are the PATIENT filling out this form, please go to "Memory Loss Questionnaire"
If you are other than the PATIENT, answer below mentioned questions

When was the first time other people recognized that the patient's cognition was not normal?_____
Give example _

Was the progression sudden or gradual in nature?_____

What were the things the patient was able to do before that he/she is not able to do anymore? _ _ _ _ _ _ _

Is the patient able to manage his/her finances? Yes / No If Yes: made any mistakes?_____
Who is helping with finances (paying bills, balancing checkbook etc.) _ _ _ _ _ _ _ _ _ _ _ _ _ _

Is the patient driving? Yes /No If Yes: made any mistakes/ gets lost? _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
If No: when did patient stop driving?_____Why?_____
Will you put your loved one in the passenger side when the patient is driv ing? Yes /No

Does the patient have "sun downing" episodes? _

Does the patient have difficulty following conversations / TV shows / sports etc.? _ _ _ _ _ _ _ _ _ _ _

Does the patient have difficulty learning new information? Yes / No If yes, example:_ _ _ _ _ _ _ _ _

Does the patient have good control of bowel and bladder? Yes/ No if No, how long? _ _ _ _ _ _ _ _

Are there any changes in the patient's personality? (Circle): irritable/ moody/ angry/ suspicious/ outbursts/ restless ness / withdrawn/ not participate in anything/ clinging/ crying easily/ hallucination (seeing or hearing things which are not there) / delusion (firmly held belief in things that are not true) / socially unacceptable behavior- cursing, poor personal hygiene, hyper sexuality.

Does the patient need help with day to day activities? (Circle): needs help making the bed, brushing teeth, toileting, bathing, shaving, choosing clothes, putting on clothes (butto ning/ unbu ttoning, tying shoe lace) eating, taking medications , using TV remote control, using microwave.

Any changes in sleep the pattern? E.g. excessive sleep during the day time, not able to sleep at night, gets day and night confused.

Are there any repetitive, purposeless behaviors? : (Circle) hand-wringing, scratching, hollering,_____

Do you smell things others don't smell? Yes/ No

Have you ever had any significant head trauma? Yes/ No

Do you have a history of concussions? Yes/ No

Do you ever have Deja'Vu? Yes/ No

Do you ever have Jama'Vu? Yes/ No

Do you have periods where you lose track of time? Yes/ No

Do you have episodes of anxiety for no reason? Yes/ No

Do you have vivid dreams? Yes/ No

Do you have sleep paralysis? Yes/ No

Do you have uncontrollable body movements? Yes/ No

For physician use only:
Safety (wandering- GPS, medical alert/ fire arm access), Living will, Code status, Health care power of attorney, Long term care planning, driving, care giver fatigue
Intervention : music, dance, walk, commands - one word, family pictures/videos, pet, friend circle, church

Patient Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ DOB:_____