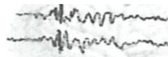

Memory Loss Questionnaire:

Who is filling out this form? (Circle)

Patient Family Member (relation :_ _ _ _ Friend Caregiver

Name of the person filling out the form: ....

If you are other than the PATIENT, please go to "Dementia Questionnaire"

If you are the PATIENT, answer below mentioned questions:

Temporal Lobe

Frequent difficulty remembering appointments? Yes/ No

Frequently misplace things? Yes/ No

Frequent difficulty finding the right words during conversations or retrieving the names of things? Yes/ No

Does the correct word/ name come back to you after sometime? Yes/ No

Frequent tendency to misinterpret what one hears, reads or experiences? Yes/ No

Frontal Lobe

Frequent difficulty thinking things through (reasoning)? Yes/ No

Frequent difficulty handling finances/ routine affairs? Yes/ No

Frequent difficulty finishing chores, tasks, or other activities? Yes/ No

Frequent difficulty with organizing and planning things? Yes/ No

Frequent feelings of boredom, loss of interest, feeling of hopelessness or helplessness? Yes/ No

Low motivation to do things that were previously enjoyed? Yes/ No

Tendency to act impulsively, such as saying or doing things without thinking first? Yes/ No

Do I have (apathy, agitation, anxiety, irritability, depression, and delusions) more often than before? Yes/ No

Parietal Lobe

Frequent wrong turns or episodes of getting lost traveling to well-known places (direction sense)? Yes/ No

Frequent problems judging where you are in relationship to objects around you? Yes/ No

Often get confused about left and right? Yes/ No

Trouble learning a new task or skill? Yes/ No

Overall

Deficits in my memory significantly hampers my daily functioning? Yes/ No

Deficits in my memory significantly hampers my job/employment functioning? Yes/ No

I can perform all my usual activities successfully? Yes/ No

Are you involved in legal matter due to your cognitive problem? Yes/ No

I see things which are not there (visual hallucinations)? Yes/ No

Do you have family history of dementia? Yes/ No If Yes, in whom________________________________

Have you ever had significant head trauma? Yes/ No If Yes, describe_ _ _ _ _ _ _ _ _ _ _ _ _ _ _

How long you are having problem with memory/ cognition?__________Years

Was the onset sudden or gradual in nature?

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

Any other details that we should be aware of?____

____

For physician use:

Education (Achievement) Major life events Medications Labs

Neuroimaging Treatments Risk Factors Sleep (OSA)

Substance, Lumosity.com, Brain food cook book "mindful!", www.alz .org, www.sm okefr ee.gov , Exercise DVD, Stress relaxation CD

Patient Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ DOB :_________________