Baylor AT&T Memory Center
9101 N. Central Expressway, Suite 230
Dallas, Texas 75231
Phone: (214) 818-5765
Fax: (214) 818-5782

Welcome to the Baylor AT&T Memory Center! We look forward to working with you and your family to provide a comprehensive evaluation and the highest quality of care.

Please find the following enclosed:

- ✓ Patient questionnaire to be completed **PRIOR** to your appointment and turned in to the receptionist upon arrival to the clinic.

Please plan to arrive at least 15 minutes prior to your appointment. You may be rescheduled if you are more than 20 minutes late for your new visit.

Please remember to bring:

- ✓ Medical insurance eligibility card and picture ID.
- ✓ Pertinent medical records including CDs and reports of available brain scans (Imaging: MRI, CT, PET; EEG; blood work; neuropsychological evaluation).
- ✓ Names, complete addresses and telephone numbers of your referring physicians.
- ✓ Completed patient questionnaire.

You MUST call at least 48 hours in advance if you need to change your appointment.

- If an emergency may arise which may cause you to cancel your appointment at the last minute, please call us and notify us so that we may reschedule your appointment.
- If you have any questions or need to reschedule your appointment, please call (**214) 818-5765.**

DIRECTIONS

- The Baylor Memory Center is located in the northwest corner of Park Lane and Central Expressway, at 9101 N. Central Expressway, Suite 230.
- From 75 North or South, exit 5B toward Northpark Blvd./Park Lane

PARKING

- Parking is located outside the clinic building and in the parking garage.
- There is no parking fee.

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NEW PATIENT CLINIC QUESTIONNAIRE

Patient Information

Last, First, Middle Name			Date:
Age	**Birthdate**	**Sex**	**Primary Language**
		Female / Male	
Referring Physician's Full Name/Address			**Telephone #**

Are you: Right-handed / Left-handed / Ambidextrous	
Why do you need to see a Neurology specialist?	

Past Medical History	**Date Diagnosed**

Hospitalizations, Operations and dates.

Head Injuries and dates. Include any episodes of loss of consciousness.

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Previous Diagnostic Tests

PET / MRI / CT of the BRAIN. Please list date as well as where completed (Imaging center or hospital name)
Neuropsychological Evaluation. (If yes, who performed the testing and year it was completed?)

SOCIAL HISTORY

Any use of tobacco (type and for how long)? ______________________________

Any use of caffeinated beverages? ______________________________

Any use of alcohol (type and for how long)? ______________________________

Any use of recreational drugs (type and for how long)? ______________________________

Any exposure to toxins/poisonous substances at work or with hobbies? ______________________________

Employment Status: Full Time Part Time Retired Disabled

Former or current occupation? ______________________________

Highest level of education? ______________________________

Marital Status: Single Married Divorced Separated Widowed

Birthplace ______________________________

Living Environment: Please provide address and name of residence, if applicable.

- ☐Home or Apartment ______________________________
- ☐Senior Community / Independent Living ______________________________
- ☐Assisted Living ______________________________
- ☐Memory Care or Nursing Home ______________________________

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MEDICATION LIST

Include current and/or recent medications and over-the-counter medications and supplements.

Name	Dose	Frequency

Have you ever been on any of the following medications?

Aricept (donepezil)	Yes	No
Exelon (rivastigmine)	Yes	No
Namenda (memantine)	Yes	No
Razadyne, Reminyl (galantamine)	Yes	No

Drug Allergies and reactions.

Preferred Local/Mail Order Pharmacy (street address, phone number and store number, if applicable):

____

____

____

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FAMILY HISTORY

Mother: Living or deceased? Age: ________

Health Problems: ______________________________

Father: Living or deceased? Age: ________

Health Problems: ______________________________

Brothers/Sisters: List from the oldest to youngest.

1. Brother or sister? Living or deceased? Age: ________

Health problems: ______________________________

2. Brother or sister? Living or deceased? Age: ________

Health problems: ______________________________

3. Brother or sister? Living or deceased? Age: ________

Health problems: ______________________________

4. Brother or sister? Living or deceased? Age: ________

Health problems: ______________________________

Children: List from oldest to youngest.

1. Son or daughter? Living or deceased? Age: ________

Health problems: ______________________________

2. Son or daughter? Living or deceased? Age: ________

Health problems: ______________________________

3. Son or daughter? Living or deceased? Age: ________

Health problems: ______________________________

Other relatives with psychiatric or neurological problems?

1. Relative 1: Living or deceased? Age: ________

Health problems: ______________________________

2. Relative 2: Living or deceased? Age: ________

Health problems: ______________________________

2. Relative 3: Living or deceased? Age: ________

Health problems: ______________________________

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REVIEW OF SYSTEMS

Please place a checkmark if you currently have any of the following symptoms.

1. "constitutional"	☐fever	☐weight loss	☐fatigue
2. "eyes problem"	☐blurred vision	☐double vision	☐loss of vision
	☐eye pain	☐eye redness	☐eye dryness
3. "ear/nose/throat"	☐trouble hearing	☐ringing in ear(s)	☐dizziness (vertigo)
	☐loss of balance	☐ear pain	☐ear discharge
	☐hoarseness	☐trouble swallowing	☐slurred speech
4. "cardiovascular"	☐chest pain	☐irregular hear beat	☐fast heartbeat
	☐limb swelling	☐limb pain on walking	☐fainting
5. "respiratory"	☐trouble breathing	☐chronic cough	☐coughing blood
6. "gastrointestinal"	☐indigestion	☐heart burn	☐abdominal pain
	☐nausea	☐vomiting	☐regurgitation
	☐diarrhea	☐constipation	☐bloody stools
7. "genitourinary"	☐incontinence	☐pain on urination	☐blood in urine
8. "musculoskeletal"	☐muscle pain	☐muscle cramp	☐muscle twitch
	☐loss of muscle bulk	☐neck pain	☐back pain
	☐joint paint	☐joint stiffness	☐joint swelling
9. "skin & breast"	☐numbness	☐tingling	☐discoloration
10. "neurologic"	☐headache	☐face pain	☐face numbness
	☐weakness	☐tremors	☐clumsiness
	☐blackouts	☐trouble with memory	☐trouble concentrating
11. "psychiatric"	☐hallucinations	☐feeling depressed	☐trouble sleeping
	☐suicidal thoughts	☐inappropriate crying	☐inappropriate laughing
12. "hematologic/ lymphatic"	☐abnormal bleeding	☐nose bleeds	☐lumps or swellings
13. "immunologic/ allergic"	☐skin rash	☐joint pain	☐dry eyes & or dry mouth
14. "endocrine"	☐excessive thirst	☐heat or cold intolerance	☐excessive urination

Person completing questionnaire: ______________________Relationship to patient: ______________________

For office use only: This questionnaire may be completed by the patient, relative or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent changes.)

Physician's Signature: ______________________________Date: _______________Time: ________________

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PHYSICIAN INFORMATION

Please list the contact information for the physicians providing patient care. We will mail or fax a copy of your consultation to the doctors you list on this sheet.

Name: ___________________________________ Specialty: ____

Address: _________________________________ City: ____

State: ______ Zip: __________ Office: ______________________________ Fax: ________________________

Name: ___________________________________ Specialty: ____

Address: _________________________________ City: ____

State: ______ Zip: __________ Office: ______________________________ Fax: ________________________

Name: ___________________________________ Specialty: ____

Address: _________________________________ City: ____

State: ______ Zip: __________ Office: ______________________________ Fax: ________________________

Name: ___________________________________ Specialty: ____

Address: _________________________________ City: ____

State: ______ Zip: __________ Office: ______________________________ Fax: ________________________

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BEHAVIOR CHECKLIST

Please place a checkmark in the appropriate column if you are experiencing any of the symptoms below.

Current Problems	MILD	MODERATE	SEVERE
Depressed Mood			
Disturbed Sleep			
Appetite Changes			
Significant Change in Weight			
Poor Concentration			
Hopelessness			
Suicidal Thoughts			
Tense/Anxious			
Fearfulness/Panic			
Obsessive Thoughts			
Compulsive Behavior			
Memory Loss			
Confusion/Disorientation			
Apathy/Loss of Interest			
Irritability/Easily Frustrated			
Suspiciousness/Paranoia			
Hostility/Anger			
Combativeness/Aggression			
Hallucinations			
Problems Maintaining Hygiene			
Word Finding or Language Problems			
Inappropriate Behavior/Loss of Social Graces			