Baylor Scott & White NEUROLOGY MCKINNEY

# Memory Disorders Questionnaire

(to be filled out with help of family / caregiver)

Does the family feel that there is a Memory / Language / Judgement / Depth Perception / Mood / Personality / Gait problem (circle any number of these) ?
d no d yes

Does the patient feel he or she has any of these problems? no yes

With hindsight, when was the problem first noticed _____

Does the patient live with anyone? no yes, who? _____

| Does the patient frequently have problems with: | No | Yes |
|---|---|---|
| Remembering appointments? | | |
| Misplacing things? | | |
| Needing conversations repeated? | | |
| Retrieving names or finding words during conversation? | | |
| Acting impulsively, such as saying or doing things without thinking first? | | |
| Feeling bored, loss of interests, depressed, feeling hopeless or helpless? | | |
| Feeling Anxious or irritable? | | |
| Having Hallucinations (hearing voices or seeing things)? | | |
| Having Delusions (firmly held belief in things that are not true)? | | |
| Getting lost when traveling to well known places? | | |
| Getting confused with left and right? | | |
| Trouble learning a new task or skill? | | |
| Organizing and planning things? | | |
| Falling? | | |
| Repetitive, purposeless behaviors (eg fiddling with hands / hollering)? | | |
| Personality changes? | | |

| Problems with: | No | Yes | What is the problem? |
|---|---|---|---|
| Hygiene (grooming, brushing, toileting) | | | |
| Controlling bladder or bowels | | | |
| Food preparations | | | |
| Taking Medications | | | |
| Hearing or Vision | | | |
| Using regular Appliances / TV | | | |
| Driving | | | |
| Job | | | |
| Managing bills | | | |

Name: DOB: Date