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)?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

Does the patient feel he or she has any of these problems?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
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With hindsight, when was the problem first noticed?

Does the patient live with anyone?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes, who?</th>
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### Does the patient frequently have problems with:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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- 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?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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### Problems with:

<table>
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<tr>
<th>Yes</th>
<th>No</th>
<th>What is the problem?</th>
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- 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_________________