Cognitive and Geriatric Neurology Team
A217 Clinical Center 804 Service Road, East Lansing, MI 48824
Fax: (517) 432-3713

New Patient Appointment Request

Please complete this form and return it to the address or fax number listed above.
After a clinician on our team reviews the information provided, we will contact you to arrange an appointment or to let you know of other community resources to seek medical help.
Thank you for your interest, and for the opportunity to be of service to you.

Date Completed ____/____/____

Patient Information:

Name: _____
Last First Middle

Address: _____

City:_____State:_____Zip:_____ Home:(_____)____-_____

Cell (_____)_____-_____ Work (_____)_____-_____

Sex:_____ Age:_____ Date of Birth:____/____/____ Place of birth:_____

Email: _____

If you need an interpreter, please bring an adult interpreter to your appt. ***If your appointment is for memory loss, you must bring the person listed below to your appointment.***

Family Member or Caregiver:

Name:_____

Relation to Patient: _____ Phone: home (_____)_____-_____
cell (_____)_____-_____ work (_____)_____-_____

Address: (if different from above)

Email: _____

Who should we contact regarding the appointment? Patient___ Caregiver___

Please circle preferred method for contacting you about appointment information: home phone___ work phone___ cell___

Patient Questionnaire (ok if completed by the family/primary caregiver):

Referring Physician:_____ Primary Care Physician:_____
Address/City:_____ Address/City:_____
Phone: ( )_____ Phone: ( ) _____

Please list any physicians, other than the above, who you would like to receive a report from us:
Physician Name/Specialty Address Telephone

_____
_____
_____
_____

Do you have a medical Durable Power of Attorney for health care?
If yes, please bring a copy Yes* No

Do you have a problem with memory? Definitely _____ Questionable ____

In what year were problems with memory first noticed? _____
Has the problem gotten worse since then? Rapidly___ Slowly___ Don't know___
Have you ever been evaluated for the problem? Yes___ No___
If so, when?_____ Where?_____
By whom?_____

In the last year, have you had blood tests done: Sparrow Lab____ McLaren Lab___ Other___
If you have had blood tests anywhere else, please provide them or have your provider send them.

Have you had brain imaging*? CT Scan___ MRI Scan___ PET Scan___
When?_____ Where?_____
Have you had a neuropsychological evaluation? Yes*___ No___
When?_____ By whom?_____

*If yes, please bring a DVD of the scan(s) & paper neuropsych report to the appointment.
DO NOT RELY ON YOUR PCP TO SEND THIS TO US.

Were you told that you definitely or probably have Alzheimer's disease? Yes___ No___
Were you told that you have some other type of memory disorder? Yes___ No___
If yes, what? _____

Please list any MEDICAL problems and approximate disgnosis dates:

Anxiety/Depression: _____	Diabetes:_____	Migraine:_____
Asthma: _____	Head Injury/trauma:_____	Peripheral Neuropathy:_____
Atrial fibrillation:_____	Heart Attack:_____	Peripheral vascular disease:_____
Autoimmune disorder:_____	Heart disease:_____	Kidney disease:_____
Brain tumor:_____	High cholesterol:_____	Renal failure: _____
Cancer:_____	High blood pressure:_____	Seizure disorder:_____
Depression:_____	Liver disease:_____	Stroke:_____
Dementia:_____	Meningitis:_____	Thyroid disease:_____

OTHERS:_____
_____

Please list any SURGERIES you have had below, with dates if known.

_____
_____
_____

FAMILY MEDICAL HISTORY

Alzheimer's___ Depression:___ High cholesterol___ Muscular Dystrophy___ Renal Failure___ Parkinson's___ Tremors___
Balance_____ Diabetes:_____ High blood pressure___ Myasthania Gravis____ Schizophrenia___ Periph.Neuropathy___
Cancer:____ Huntinton's Disease___ Migraine___ Heart attack___ Stroke___ Peripheral vascular disease____
Coronary artery dis. <55___ Bleeding disorder___ Multiple sclerosis___ Poly. kidney dis.___ Stroke<age 55___ Seizure____

Please list any immediate family members who have passed away:

Relationship: Age at death: Cause of death:

_____
_____
_____
_____

List all medicines you take. **(Include <u>ALL</u> prescription, non-prescription, vitamins, supplements and natural products**)

Current Medication	What strength?	How do you use it? (How many? How many times a day?)
Example: Tylenol	***500mg***	***1 pill 3x a day***

Do you have any drug allergies? Yes No
If yes, please list name of drug and specify reaction.

	Indicate Reaction			
Name of Drug	**Rash**	**Shortness of Breath**	**Nausea**	**Other (specify)**

SOCIAL

HISTORY: Race: **Ethnicity:**

◯ White ◯ American Indian / Alaska Native ◯ Asian ◯ Hispanic / Latino ◯ Decline

◯ African American ◯ Native Hawaiian / Pacific Islander ◯ Undetermined ◯ Not Hispanic / Latino

Language Preference: _____

Are you on a special diet: _____

How often do you exercise? _____

Smoking/Tobacco Use:

Do you currently or have you ever used tobacco?

◯ Yes, daily	◯ Yes, occasionally	◯ No, never	◯ Quit smoking/using tobacco
If YES, how much? _____	Packs per Day	Date Quit: _____	
Have you been exposed to second hand smoke?	☐ Yes, current	☐ Yes, past	☐ No

Marital & Family Status:

Single___ Married___ Divorced___ Widowed___ Domestic Partner___

How many children do you have? _____ Are you in regular contact with them? _____

Education:

What is the highest grade level you have completed? _____

Have you ever had a learning disability? _____

Did you have childhood attention deficit disorder?_____

Living Arrangements (Please choose the living arrangement that best describes your own):

House___ Apartment___ Assisted Living___ Nursing Home___ Adult Foster Care___

Live Alone___ With spouse___ With Children___

Employment Status:

Employed___ Unemployed___ Retired___ Disabled___ Occupation:_____

If employed, where?_____

Alcohol:

Do you drink alcohol, including beer, wine, or spirits (such as vodka, whiskey, gin)?

Daily ___ A few days per week___ (how many?____)

Less than once a week ___ Never___

How much do you drink at a time? (one drink = 12 oz of beer or 8-9 oz of malt liquor or 5 oz of table wine or 1.5 oz of hard alcohol.) _____drinks

Has anyone ever been concerned about your drinking? Yes___ no___

Have you:

Used cocaine, heroin or speed? If so, for how long? _____
Had more than one concussion in your life? _____
Been on a ventilator in the Intensive Care Unit? _____
Had to have your heart "restarted" (been given cardiopulmonary resuscitation/CPR)?_____
Played tackle football or boxed for more than 2 years? _____
Had open heart surgery requireing a bypass machine? _____
Had a stroke? _____ If yes, how many? _____

Did you have a parent with dementia/Alzheimer's before the age of 75? _____
Do/did you have a sibling with dementia/Alzheimer's before the age of 75? _____

Questions for the Family or Caregiver:

What is/are your goal(s) for this evaluation?

_____

_____

_____

Do you belong to a support group? Yes No

Do you have someone who can give you some relief if you need to go to the doctor, hair dresser, or out to see friends? Yes No

Who	Relationship	How Often	How Long

What was/is your occupation?_____

Do you feel you need:

- Help with making a diagnosis? Yes No
- Help with managing patient's behavior? Yes No
- Help with handling your own feelings? Yes No
- Help in other areas? (Please comment) Yes No

_____

_____

_____

Would you be interested the following services for the patient?

- Participation in research projects/drug studies? Yes No
- Medication review by a pharmacist? Yes No
- Assessment of independent living skills? Yes No
- Independent driving evaluation? Yes No
- Fall risk assessment Yes No
- Information about community resources? Yes No
- Family or couples therapy/counseling Yes No

Please complete the following in regards to the patient's activities of daily living.

Task	Help Needed	Details: Type of help needed
Using the telephone	Y / N	
Managing their medicines (like taking medicines on time)	Y / N	
Preparing meals	Y / N	
Managing money (like keeping track of expenses or paying bills)	Y / N	
Doing housework (such as doing the laundry)	Y / N	
Shopping for personal items like toiletries or medicines	Y / N	
Shopping for groceries	Y / N	
Driving	Y / N	
Feeding self	Y / N	
Getting from bed to chair	Y / N	
Getting to the toilet	Y / N	
Getting dressed	Y / N	
Bathing or showering	Y / N	
Walking across the room (includes using cane or walker)	Y / N	
Climbing a flight of stairs	Y / N	
Getting to places beyond walking distance (e.g. by bus, taxi, or car)	Y / N	

Does the patient have any of the following problems with mood or behavior? (Check all that apply)

Impatient, cranky, irritable, or resistive to help ____

Depression, sadness, or crying spells ____

Abnormal happiness ____

Sleep problems (too much or too little) ____

Nervous or worrying ____

Restlessness, rummaging or pacing ____

Loss of interest in usual activities ____

Paranoia or false beliefs ____

Hallucinations (false visions or voices) ____

Impulsive or embarrassing behavior ____

Physical aggression ____

Changes in appetite, weight, or eating habits ____

Hoarding ____

Remarks: Please use this space to provide any other information you think might be helpful in evaluating the patient's memory problem.

_____

_____

_____

_____

_____

_____

If you have any questions about completing this form, please call 517 353-8122 and speak with a Patient Services Representative.

Thank you