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).
- ✓ 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.

BAYLOR AT&T MEMORY CENTER
NEW PATIENT CLINIC QUESTIONNAIRE

PATIENT INFORMATION

Name			Date
Age	Birthdate	Sex ☐ Female ☐ Male	Primary Language
Referring Physician's Full Name		Primary Care Physician's Full Name	
Are you: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous			
Primary Concern(s)			

PAST MEDICAL HISTORY: Please place check mark.

Neurological:
- ☐ Parkinson's Disease
- ☐ Tremor
- ☐ Seizure Disorder
- ☐ Past Head Injury
- ☐ Migraine
- ☐ Neuropathy

Heart/Vascular Disease/Stroke:
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease: If yes, is there a history of:
  - ☐ Coronary Artery Bypass Surgery
  - ☐ Angioplasty/Stents
  - ☐ Pacemaker
- ☐ Stroke/CVA
- ☐ Transient Ischemic Attack
- ☐ Subdural Hematoma (Brain Bleed)

Lung Disease:
- ☐ COPD
- ☐ Asthma
- ☐ On Oxygen

Gastrointestinal:
- ☐ Gastrointestinal Bleed
- ☐ Chronic Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Chronic Diarrhea
- ☐ Crohn's Disease
- ☐ Ischemic Colitis
- ☐ Gastroesophageal Reflux Disease (GERD)

Endocrine:
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Autoimmune:
- ☐ Multiple Sclerosis
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's

Kidney and Liver:
- ☐ Chronic Kidney Disease
- ☐ Hepatitis
- ☐ Cirrhosis

Ear/Nose/Eye:
- ☐ Hearing Loss
- ☐ Seasonal Allergies
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataracts

Other: Cancer (list types): ______________________________

Chronic Pain (list areas): ______________________________

Other Pertinent Health History: ______________________________

____

SURGICAL HISTORY: ______________________________

____

Scan doc type: Patient Questionnaire

BAYLOR AT&T MEMORY CENTER
NEW PATIENT CLINIC QUESTIONNAIRE

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 alcohol (type and for how long)? ______

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

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled

Former or current occupation? ______

Highest level of education? ______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Number of biological / adopted children: ______

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 ______

FAMILY HISTORY

Neurologic or Psychiatric disease (e.g. dementia) ______

______

______

______

MEDICATION LIST

Provide current prescribed and over-the-counter medications including supplements, or attach prepared list.

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.

Scan doc type: Patient Questionnaire

BAYLOR AT&T MEMORY CENTER
NEW PATIENT CLINIC QUESTIONNAIRE

REVIEW OF SYSTEMS

Please place a check mark 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.)

BAYLOR AT&T MEMORY CENTER
NEW PATIENT CLINIC QUESTIONNAIRE

BEHAVIOR CHECKLIST

Please place a check mark 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			

Scan doc type: Patient Questionnaire

BAYLOR AT&T MEMORY CENTER
NEW PATIENT CLINIC QUESTIONNAIRE

NEUROPSYCHOLOGICAL SYMPTOM CHECKLIST

Below is a list of questions about your health and health habits. Please think very carefully and check every problem that applies. If you are not sure what the question means or not sure of your answer just draw a circle around the question and the doctor will help you with it later. Just be sure to answer every question.

Do you have...

1. ☐ change in smell
2. ☐ change in taste

Are you...

3. ☐ blind in left eye
4. ☐ blind in right eye
5. ☐ blind in both eye

Do you...

6. ☐ wear glasses
   ☐ glasses for reading only
7. ☐ wear contacts

Do you have...

8. ☐ blurred vision
9. ☐ double vision
10. ☐ loss of vision
11. ☐ blank spots in vision
12. ☐ flashing lights in vision

Are you...

13. ☐ deaf in left ear
14. ☐ deaf in right ear
15. ☐ deaf in both ears

Do you...

16. ☐ wear a hearing aid

Have you had...

17. ☐ hearing loss
18. ☐ ringing in the ears
19. ☐ strange sounds in ears

Do you have...

20. ☐ any paralysis
21. ☐ muscle weakness
22. ☐ muscle twitching
23. ☐ muscle spasms
24. ☐ trouble walking
25. ☐ coordination problems
26. ☐ balance problems
27. ☐ tremors or shakiness
28. ☐ problems with dropping things

Have you had...

29. ☐ numbnes
30. ☐ tingling skin
31. ☐ pins and needles
32. ☐ burning skin
33. ☐ loss of feeling
34. ☐ loss of telling hot from cold
35. ☐ change in skin

Do you have...

36. ☐ pain
37. ☐ headaches

Have you had...

38. ☐ blackout spells
39. ☐ seizures
40. ☐ fainting spells
41. ☐ periods where you lose time

Do you...

42. ☐ get lost often
43. ☐ forget where you are
44. ☐ forget time and day
45. ☐ forget meetings
46. ☐ forget names of people you know
47. ☐ misplace or lose items
48. ☐ repeat yourself
49. ☐ have memory problems
50. ☐ hear unusual sounds
51. ☐ have strange feelings

Does it seem that you...

52. ☐ can't think as quickly
53. ☐ find it hard to think clearly
54. ☐ are more easily distracted
55. ☐ can't concentrate
56. ☐ have trouble with common sense

Have you had trouble:

57. ☐ using tools
58. ☐ telling right from left
59. ☐ getting dressed
60. ☐ with numbers
61. ☐ remembering right word when talking
62. ☐ following conversations
63. ☐ understanding what you read
64. ☐ understanding others
65. ☐ with your speech
66. ☐ with reading
67. ☐ with writing

Have you had problems with...

68. ☐ sadness or depression
69. ☐ worry or guilt
70. ☐ stress or anxiety
71. ☐ anger or keeping your temper
72. ☐ change in your attitude
73. ☐ loss of interest

Have you had...

74. ☐ childhood diseases or injuries
75. ☐ head injuries
76. ☐ problems with nerves
77. ☐ high fevers

Do you...

78. ☐ work with chemicals, if so please list which ones:

____

____

____