

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) ?

no 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 _____