Elliot Memory
& Mobility Center
Preserving Independence

Please mail back in the enclosed envelope if time permits. Otherwise, bring this form to your appointment at _____ am/pm on:

_____

PRE-VISIT MEDICAL QUESTIONNAIRE

INSTRUCTIONS

Please answer the following questions about your medical health. Although this form is lengthy, it is designed to be very thorough. Completing this information before your appointment will greatly assist the doctor to be focused in your exam and best use your time together.

Name of Patient: _____ Date of Evaluation: _____

If you are completing this form on behalf of the patient, please fill in this box:

_____ _____
NAME RELATIONSHIP TO PATIENT

_____
PHONE NUMBER

DEMOGRAPHICS

STREET: _____ APT. _____

CITY: _____ STATE _____ ZIP: _____

PHONE (Home): _____ Cell: _____

DATE OF BIRTH: _____ AGE: _____ SEX: ❑ Male ❑ Female

Who is your **primary doctor**? Dr. _____
Current or most recent primary physician

Address: _____

_____

Phone number: ( ) _____

Fax Number: ( ) _____

PRESENTING PROBLEM

Who referred you to the Memory Clinic? _____

May we contact the referring physician? ☐ No ☐ Yes

Please briefly describe what memory problem(s) you are experiencing:

_____

_____

_____

_____

_____

_____

_____

Did these changes have an **abrupt onset** (for example, normal one day and then problems the next)? ☐ No ☐ Yes

Did these changes have a **gradual onset** (for example, slowly worsening over time)? ☐ No ☐ Yes

Please describe **when** the problems started, and the **pattern** of the problems up until the present:

_____

_____

_____

Have you noticed any of these additional symptoms? Please check those that apply to you and provide an example in the space below (for example: if you answer yes to being easily distracted, your example may be "difficulties watching full TV show").

A. Attention

☐ No ☐ Yes Easily distracted

☐ No ☐ Yes Difficulties staying on task

_____

_____

_____