Montefiore

MRN: ______________________

Patient Name: ________________

DOB: ______________________

MONTEFIORE/EINSTEIN
CENTER FOR THE AGING BRAIN
PRE-VISIT PATIENT QUESTIONNAIRE

****We highly recommend completing the following form with a caregiver or family member****

Thank you for investing the time to complete this form before your visit. The information you provide here will allow your care manager to perform the most complete evaluation possible when you arrive for your appointment. Your time and effort is must appreciated.

1. Date form completed: ____________/____________/____________
Month Day Year

2. Name of patient: ____
Last First

3. Home Address: ____
Street Apartment

____
City State Zip

4. Phone: (__________)________________________

5. Date of birth: ____________/____________/____________
Month Day Year

6. Sex: ☐ Male ☐ Female

7. What's your primary language spoken? ____

Secondary? ____

8. Who filled out this form? ☐ Self ☐ Other (please give name below)

Name:______________________ Phone number: (_______) ______________

Address:______________________________ ______________
Street Apartment

______________________________ __________ __________
City State Zip

Email address: ______________________________

If other person completed this form, what is the relationship of the person to the patient?

☐ Spouse ☐ Child ☐ Friend ☐ Other (specify): ______________

What is the best time during business hours to contact this person? ______________

9. Who has been the patient's primary care doctor? Name ______________________

Address:______________________________ ______________
Street Apartment

______________________________ __________ __________
City State Zip

Phone number: (_______)______________ Fax number: (______) ______________

10. SPECIALIST(S)

Do you currently have a specialist (e.g. neurology or psychology) that manages your Alzheimer's disease, dementia or mood disorder? ☐ Yes ☐ No

If yes: Name: ______________________________

Address:______________________________ ______________
Street Apartment

______________________________ __________ __________
City State Zip

Phone number: (_______)______________ Fax number: (______) ______________

11. ALLERGIES

Do you have any drug allergies? ☐ Yes ☐ No

If yes, please list name of drug and indicate reaction.

Name of Drug	Describe Reaction
1.	
2.	

12. MEDICATIONS

List all medications, including all prescription, non-prescription, 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
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

13. PAST MEDICAL HISTORY

Which medical conditions do you have now or have had in the past?

(Please check all that apply)

EYE & EAR

- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss/hearing aid
- ☐ Other (specify):____________________

HEART

- ☐ Heart attack, year:__________
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Aortic stenosis
- ☐ Heart valve problem
- ☐ Angina
- ☐ High cholesterol
- ☐ Pacemaker
- ☐ Atrial fibrillation
- ☐ Irregular heartbeats (arrhythmias)
- ☐ Other (specify):____________________

GASTROINTESTINAL TRACT

- ☐ Heartburn/reflux/GERD
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Liver disease/cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Colon polyps
- ☐ Diverticulosis
- ☐ Bleeding problems
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Other (specify):____________________

LUNGS

- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Recurrent pneumonias
- ☐ Other (specify):____________________

KIDNEY & URINARY TRACT

- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Enlarged prostate
- ☐ Urinary incontinence
- ☐ Kidney stones
- ☐ Other (specify):____________________

BONES & JOINTS

- ☐ Gout
- ☐ Lower back pain
- ☐ Osteoporosis
- ☐ Arthritis (indicate location):
  - ☐ hip
  - ☐ knee
  - ☐ shoulder
  - ☐ back
  - ☐ hands
- ☐ Fractured bone (indicate location)
  - ☐ hip
  - ☐ spine
  - ☐ wrist
  - ☐ Other (specify):________________

GLANDS

☐ Thyroid overactive (high)
☐ Thyroid underactive (low)
☐ Diabetes
☐ Other (specify):________________

NERVOUS SYSTEM

☐ Epilepsy or seizures
☐ Parkinson's disease
☐ Other (specify):________________
☐ Stroke
☐ Neuropathy/nerve damage

OTHER HEALTH PROBLEMS

☐ Thrombosis/blood clots: ☐ in the leg ☐ in the lung
☐ Syncope (loss of consciousness)
☐ Sexual function problems (specify):________________
☐ Cancer:
- ☐ Breast
- ☐ Prostate
- ☐ Colon/rectum
- ☐ Skin
- ☐ Lymphatic
- ☐ Lung

☐ Other (specify):________________

14. HOSPITALIZATIONS/SKILLED NURSING VISITS

Please list all hospitalizations including neuropsychiatric hospitalizations for the last 5 years.

Which Hospital/Skilled Nursing Facility?	Reason for Hospitalization/SNF Visit	Year

15. Do you have access to a medical professional for advice on dementia-related issues at all times (24 hours a day/7 days a week?) ☐ Yes ☐ No

16. SOCIAL HISTORY

A. With whom do you live?
(Please check all that apply)
- ☐ Alone
- ☐ Spouse or Partner
- ☐ Child
- ☐ Other family member (specify): ________________
- ☐ Others, not family (specify): ________________

B. Which of the following best describes your residence?
- ☐ Single-family house
- ☐ Condo
- ☐ Apartment
- ☐ Board & Care/Assisted living
- ☐ Nursing Home
- ☐ Other (specify):________________

C. You are presently:
- ☐ Single/Never married
- ☐ Married
- ☐ Divorced/Separated
- ☐ Widowed
- ☐ Living with significant other

D. How many children do you have?
Number:________________

Are you in regular contact with your children? ☐ Yes ☐ No

E. How much school did you complete?
- ☐ Less than 8th grade
- ☐ Some high school
- ☐ High school graduate
- ☐ Some college
- ☐ College graduate
- ☐ Graduate school

F. Please specify your ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

G. Please specify your race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Pacific Islander
- ☐ White

H. List your principal occupation and any other significant past occupations

1.________________________
2.________________________
3.________________________

I. Who would you call if you were sick and needed help? (check all that apply)

- ☐ Spouse/Partner
- ☐ Daughter
- ☐ Son
- ☐ Neighbor
- ☐ Friend
- ☐ Other (specify):____________________

1. Please list name(s) and phone number(s):

   Name:____________________________ Phone number: (_______)_________________

   Name:____________________________ Phone number: (_______)_________________

   Name:____________________________ Phone number: (_______)_________________

2. Do we have your permission to speak to the person(s) listed above on your behalf?

   ☐ Yes ☐ No

J. Do you employ someone to provide health related care or help you in your home?

☐ Yes ☐ No

1. If yes, how many hours per day and days per week, is the paid helper available to you?________Hours________Days per week (e.g. 3 hours, 5 days per week)

2. Is this sufficient to meet your needs? ☐ Yes ☐ No

K. Do you get help from family members or friends in your home?

☐ Yes ☐ No

1. If yes, how many hours per day and days per week, is the helper available to you?________Hours________Days per week (e.g. 3 hours, 5 days per week)

2. Is this sufficient to meet your needs? ☐ Yes ☐ No

3. Please name family/friend who provides help:__________________________________

4. If this family/friend were to get sick/hospitalized, who would provide help?

   ____

L. Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whisky, gin)?

- ☐ Daily
- ☐ A few days a week (specify number of days:___________)
- ☐ Less than once a week
- ☐ Never

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

   ☐ 1 drink ☐ 2 drinks ☐ 3 drinks ☐ 4 drinks ☐ 5+ (how many?____)

2. Has anyone ever been concerned about your drinking? ☐ Yes ☐ No

M. Do you currently participate in any regular activity improve or maintain your physical fitness? (either on your own or in a formal class) ☐ Yes ☐ No

If yes, which ones:

- ☐ Bicycling or stationary bike
- ☐ Aerobics or exercise classes
- ☐ Dancing
- ☐ Jogging
- ☐ Walking
- ☐ Swimming
- ☐ Tennis
- ☐ Golf
- ☐ Bowling or bocce
- ☐ Yoga
- ☐ Pilates
- ☐ Other (specify):_______________________________

Days per week	Amount of time per day
☐ 1 ☐ 2 ☐ 3 ☐ 4	________Minutes
☐ 5 ☐ 6 ☐ 7	________Hours

17. FAMILY HISTORY

A. Have any members of your family had memory problems? ☐ Yes ☐ No

18. DRIVING

A. Do you have a valid Driver's License? ☐ Yes ☐ No

B. If yes, are you currently driving? ☐ Yes ☐ No

C. When was your last eye exam?______________________________

19. SAFETY

A. Do you always wear a seat belt when you ride in a car? ☐ Yes ☐ No

B. Do you own any firearms? ☐ Yes ☐ No

C. Are there any firearms in your home? ☐ Yes ☐ No

D. Do you have a history of wandering or getting lost while outside of the home?
☐ Yes ☐ no

20. PLANNING FOR FUTURE HEALTH CARE

Who should speak for you if you're unable to make health decisions?

Name: ____

Relationship: ____

Phone number: (__________)____________________

Do you have a living will/advance directive/out of hospital DNR form?

☐ Yes ☐ No ☐ Unsure

If yes, please bring a copy

21. Geriatric Assessments

Activities of Daily Living	Dependent	Independent	Who Helps?
Bathing			
Dressing			
Eating			
Toileting			
Transferring			
Continence			
Overall Assessment			

Instrumental Activities of Daily Living	Dependent	Independent	Who Helps?
Transportation			
Meal/Food Preparation			
Shopping Errands			
Housekeeping/Chores			
Money Management/Finances			
Medication Management			
Ability to Use Telephone			
Laundry			
Overall Assessment			

Daily Activities Continued

A. Do you use a walking aid such as a cane or a walker? ☐ Yes ☐ No

If yes, which ones? ☐ Cane ☐ Walker ☐ Wheelchair

B. Are you afraid of falling? ☐ Yes ☐ No

C. Have you had a fall in the past year? ☐ Yes ☐ No

If yes, please describe the circumstances surrounding the fall:

Did you trip over something?	☐ Yes	☐ No
Did you have lightheadedness or palpitation prior?	☐ Yes	☐ No
Did you lose consciousness?	☐ Yes	☐ No
Were you injured?	☐ Yes	☐ No
Did you need to see a doctor?	☐ Yes	☐ No
Were you able to get up by yourself?	☐ Yes	☐ No

22. During the LAST 3 MONTHS have you had any of the following symptoms or problems?

(Please check all that apply)

A. General Problems

☐ Weight loss
☐ Weight gain
☐ Change of appetite
☐ Wandering

B. Ear, Nose, Mouth, Throat

☐ Trouble hearing
☐ Swallowing problems
Special diet? ____________
Consistency? ____________
☐ Teeth problems

C. Eyes

- ☐ Trouble seeing

D. Skin Problems

- ☐ Rash
- ☐ Ulcers
- ☐ Itching
- ☐ Easy bruising

E. Lung Problems

- ☐ Cough when eating
- ☐ Difficulty breathing or shortness of Breath

F. Mood/Sadness Problems

- ☐ Depression
- ☐ Anxiety
- ☐ Sleepiness
- ☐ Fatigue
- ☐ Lack of sleep

G. Heart Problems

- ☐ Chest pain or tightness
- ☐ Lightheadedness
- ☐ Irregular heart beat
- ☐ Rapid heart beat

H. Bone and Joint Problems

- ☐ Leg pain or walking
- ☐ Back or neck pain
- ☐ Joint pain or stiffness
- ☐ Foot problems
- ☐ Balance problems
- ☐ Falls

I. Brain and Nervous System Problems

- ☐ Frequent headaches
- ☐ Frequent dizzy spells
- ☐ Passing out or fainting
- ☐ Paralysis, leg or arm weakness
- ☐ Numbness or loss of feeling
- ☐ Tremor or shaking
- ☐ Problems with sleep
- ☐ Hallucinations
- ☐ Delusions (false beliefs)

J. Digestive Problems

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Frequent indigestion or heartburn
- ☐ Frequent nausea or vomiting
- ☐ Persistent constipation
- ☐ Frequent diarrhea
- ☐ Bleeding from rectum
- ☐ Black bowel movement

K. Kidney & Urinary Tract Problems

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Difficulty starting or stopping urination
- ☐ Frequent urination infection
- ☐ Urination at night
  if yes, how many times a night: ____
- ☐ Loss of urine or getting wet
  If yes:
  - ☐ Sudden urge to void
  - ☐ Loss with cough or laugh
  - ☐ Continuous leakage
  - ☐ Hard to start urination
  - ☐ Cannot empty bladder
  - ☐ Problem getting to toilet

23. Access to Resources & Services

A. Is anybody helping you get information or services you need?

☐ Yes ☐ No

B. What outside services have you received in the past? (*List all*)

____

____

C. Please check the appropriate box for each service to indicate the service you are currently receiving and what services, *if any*, you would be interested in receiving.

Caregiver Services

Currently receiving	Interested in receiving	
☐	☐	Respite or break for caregiver
☐	☐	Caregiver Support Group
☐	☐	Consultation or help in planning for board and care or assisted living placement
☐	☐	Hospice Care
☐	☐	Private In-Home care (privately paid caregiver)
☐	☐	In-Home Supportive Services (state funded program)

Day-To-Day Services

Currently receiving	Interested in receiving	
☐	☐	Transportation (e.g. subsidies, public, door-to-door services)
☐	☐	Nutrition Services (meal delivery, shopping, meal preparation)
☐	☐	Supplies (e.g. toiletries, clothing, etc.)
☐	☐	Housekeeping
☐	☐	Medications management
☐	☐	Adult Day Care services
☐	☐	Access to communication (e.g. TTY, instruments for the hearing impaired)
☐	☐	Work accommodation (e.g. flexible hours, job modification)
☐	☐	Home Health Care
☐	☐	Home safety modification (e.g. bathroom bars, commodes, etc.)

Social Services

Currently receiving	Interested in receiving	
☐	☐	Benefits Counseling (e.g. Medicare Part D, Supplemental Security Income, Social Security)
☐	☐	Financial counseling (e.g. money mgmt, debt or foreclosure counseling)
☐	☐	Social Work services
☐	☐	Housing services (e.g. subsidized housing, discrimination, landlord disputes, homelessness)
☐	☐	Care coordination
☐	☐	Veteran's services
☐	☐	Legal advocacy

D. Financial Concerns: Do you have any concerns regarding patient finances (e.g. paying for caregiver)? Check all that apply.

_____ Yes, current concerns

_____ No concerns now, but maybe in the future

_____ No concerns at all

E. Legal Concerns: Do you have any legal concerns
(e.g. conservatorship, advance directives)? Check all that apply.

_____ Yes, current concerns

_____ Yes, future concerns

_____ No concerns

24. Please list specific health concerns that you would like the care managers to know about before your visit.

Please be sure to include any information not already reported in this form.

1)

2)

3)

4)

5)

THANK YOU FOR COMPLETING THIS FORM
AND FOR CHOOSING THE MONTEFIORE-EINSTEIN CENTER
FOR THE AGING BRAIN

Caregiver Self-Assessment Questionnaire

How are you?

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own wellbeing. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

During the past week or so, I have...

1. Had trouble keeping my mind on what I was doing ☐ Yes ☐ No
2. Felt that I couldn't leave my relative alone ☐ Yes ☐ No
3. Had difficulty making decisions ☐ Yes ☐ No
4. Felt completely overwhelmed ☐ Yes ☐ No
5. Felt useful and needed ☐ Yes ☐ No
6. Felt lonely ☐ Yes ☐ No
7. Been upset that my relative has changed so much from his/her former self ☐ Yes ☐ No
8. Felt a loss of privacy and/or personal time ☐ Yes ☐ No
9. Been edgy or irritable ☐ Yes ☐ No
10. Had sleep disturbed because of caring for my relative ☐ Yes ☐ No
11. Had a crying spell(s) ☐ Yes ☐ No
12. Felt strained between work and family responsibilities ☐ Yes ☐ No
13. Had back pain ☐ Yes ☐ No
14. Felt ill (*headaches, stomach problems or common cold*) ☐ Yes ☐ No
15. Been satisfied with the support my family has given me ☐ Yes ☐ No
16. Found my relative's living situation to be inconvenient or a barrier to care ☐ Yes ☐ No
17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. ______________
18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. _________

Comments:
(*Please feel free to comment or provide feedback*)

____

____

____

____

____

____

____

____

For additional tools for caregiving or aging, visit www.CaregiversLibrary.org

Self-evaluation:

To Determine the Score:

1. Reverse score questions 5 and 15. *(For example, a "No" response should be counted as a "Yes" and a "Yes" response should be counted as a "No")*
2. Total the number of "yes" responses.

To Interpret the Score:

Chances are that you are experiencing a high degree of distress:

- If you answered "Yes" to either or both Questions 4 and 11; or
- If your total "Yes" score = 10 or more; or
- If your score on Question 17 is 6 or higher; or
- If your score on Question 18 is 6 or higher.

Next steps:

- Consider seeing a doctor for a check-up for yourself.
- Consider having some relief from caregiving. (Discuss with the doctor or social worker the resources available in your community.)
- Consider joining a support group.

Valuable Resource for Caregivers:

Eldercare Locator:
(a national directory of community services)
1-800-677-1116
www.aoa.gov/elderpage/locator.html

Family Caregiver Alliance
1-415-434-3388
www.caregiver.org

Medicaid Hotline
Baltimore, MD
1-800-638-6833

National Alliance for Caregiving
1-301-718-8444
www.caregiving.org

National Family Caregivers Association
1-800-896-3650
www.nfcacares.org

National Information Center for Children and Youth with Disabilities
1-800-695-0285
www.nichcy.org

Local Resources and Contacts:

For additional tools for caregiving or aging, visit www.CaregiversLibrary.org