DEMENTIA QUESTIONNAIRE

(To be completed by caregiver/person knowledgeable about history and behavior)

Completed by _____

COGNITIVE SYMPTOMS

1. How long ago did you first notice evidence of cognitive decline/dementia? _____

2. Which of the following symptoms are present (indicate all that apply), and for how long?
    1. forgetting recent events _____
    2. getting lost _____
    3. problems with paying bills/finances _____
    4. problems with self-care such as grooming, eating, dressing _____
    5. inappropriate behaviors--socially inappropriate speech, anger outbursts _____
    6. apathy (lack of interest in usual activities) _____

3. Was the patient previously evaluated by a health professional for the dementia symptoms?
    1. If so, when _____
    2. Was an MRI, CT or PET scan done? If so, please indicate type of test, approximate date, and any results _____

       _____
    3. Was neuropsychological testing done by a psychologist? If so, please provide any available details about results _____

       _____

4. Please indicate which of the following medications have been prescribed and specify dose if known.
    1. Aricept (donepezil)
        i. 5mg
        ii. 10mg
    2. Reminyl (galantamine)

        i. 4mg
        ii. 8mg
        iii. 16mg
        iv. 24mg
    3. Exelon (rivastigmine) capsule or patch
        i. Capsule
            1. 1.5mg
            2. 3mg
            3. 4.5mg
            4. 6 mg
        ii. Patch
            1. 4.6mg
            2. 9.5mg
            3. 13.3mg
    4. Namenda (memantine)
            1. 5mg
            2. 5mg twice daily
            3. 10mg
            4. 10mg twice daily
            5. XR 7mg
            6. XR 14mg
            7. XR 21mg
            8. XR 28mg

5. The medication(s)_____ (please indicate all that apply)
    1. had no clear benefit
    2. caused significant side effects
    3. improved memory/cognition
    4. improved mood
    5. improved delusions (false beliefs)
    6. improved agitation

LIVING SITUATION/SUPPORT/SAFETY

1. Does the patient live alone or with a family member? _____

2. Have you had to hire caregiver(s) to help with care and safety? Yes/No

    a. If yes, please indicate when such help was first hired _____

    b. For how many hours/day is the caregiver present? _____

3. Which of the following activities does the caregiver help with:

    a. dressing

    b. meal preparation/serving

    c. bathing/shower

    d. medication administration

    e. ambulation/moving from place to place in home

    f. transportation

3. Does the patient ever use the stove, or potentially dangerous appliances/tools? Yes/No

4. Does the patient drive? Yes/No

5. If not, when did the patient stop driving? _____

5. Was a report filed with DMV? Yes/No/not known

Please provide any other information you feel is important regarding driving.

_____

_____

_____

_____

MOOD/BEHAVIORAL SYMPTOMS

1. The patient seems depressed
    1. rarely/never
    2. some of the time but less than half the time
    3. about half the time
    4. most of the time

2. The patient seems anxious
    1. rarely/never
    2. some of the time but less than half the time
    3. about half the time
    4. most of the time

3. The patient has delusional thoughts (false beliefs) that cause distress.
    1. never
    2. less than once a week
    3. once a week
    4. a few times a week
    5. most days of the week
    6. daily

4. Which of the following types of delusional thoughts does the patient have? Please indicate all that apply:
    1. believes that someone is stealing things from him/her
    2. believes that someone is trying to cause physical harm to him/her
    3. believes that spouse is having an affair
    4. believes that a stranger is living in the home
    5. believes that his/her home is not actually home
    6. thinks he/she needs to go somewhere (home, trip, etc.)
    7. thinks that family members are impostors who look like family members
    8. thinks that reflection in mirror is a stranger
    9. other (please describe) _____

5. Have there been times where the patient seems to see or hear people, animals, or things that are not really there (hallucinations)? Yes/No.

6. If hallucinations have occurred, was the experience distressing to the patient? Yes/No

7. If hallucinations have occurred, please indicate below the frequency :
    1. rarely (happened only a few times)
    2. about once a week
    3. a few times a week
    4. daily
8. Please describe below an example of a hallucination experienced by the patient:

9. How often does the person with dementia (patient) have episodes of being agitated (extremely anxious, angry, fearful) related to delusions or other causes?
    1. never
    2. rarely
    3. once a week
    4. several times a week
    5. daily

10. Agitation usually occurs at the following time(s) of day:
    1. morning
    2. afternoon
    3. evening
    4. in middle of night/early morning

11. Most often, the agitation occurs (please check all that apply):
    1. when caregiver tries to assist with daily care needs (waking, dressing, showering)
    2. when patient is redirected from problematic behaviors (wandering, taking items out of drawers, etc.)
    3. because of delusional beliefs
    4. without a clear reason

12. When agitated, the patient (please indicate all the apply):
    1. yells
    2. attempts to push, strike others
    3. throws things
    4. other _____

13. Episodes of agitation:
    1. last 30 minutes or less
    2. last up to 1 hour
    3. last up to 2-3 hours
    4. persist for several hours

14. The patient has problems sleeping at night:
    1. never
    2. a few times a week
    3. most nights
    4. every night

15. The patient sleeps during the day:
    1. very little (1 hours or less)
    2. up to 2 hours
    3. up to 3-4 hours
    4. more than 4 hours

16. Does the patient wander away from home and get lost if unsupervised?
    1. Yes
    2. No

17. Apart from daily grooming/dressing, eating, please list below how the patient spends his/her time during the day.