

Memory Loss Evaluation: Initial Visit

(Name)		
Date: _____	Story of the Memory Problem	
Age: _____		
Fam Rpt: Beh 3=unable; 0=able	ROS	
checkbook _____	circle positives	
taxes _____	personality	
shopping _____	speech	
games _____	weakness	
stove _____	judgment	
meal prep _____	confusion	
events _____	alertness	
TV, book _____	delusions	
appointments _____	hallucinations	
travel _____	emotional	
SCORE _____	sensory	
	mouth	
	fall,injury	
	balance	
	snore	
	short of breath	
	cough	
	bowel	
	hematochezia	
	sex dysfxn	
	incontinence	
	joint pain	
	extremities	
	skin	
	appetite	
	thirst	
	fatigue	
	sleep	
	wt change	
	food	
Past Med Hx	Current medical history	
check positives		
HTN <input type="checkbox"/>		
CAD <input type="checkbox"/>		
thyroid <input type="checkbox"/>		
cholesterol <input type="checkbox"/>		
CVA <input type="checkbox"/>		
neuropathy <input type="checkbox"/>		
periph vasc <input type="checkbox"/>		
diabetes <input type="checkbox"/>		
hepatitis <input type="checkbox"/>		
head injury <input type="checkbox"/>		
Parkinson's <input type="checkbox"/>		
alcohol <input type="checkbox"/>		
depression <input type="checkbox"/>		
VD <input type="checkbox"/>		
seizures <input type="checkbox"/>		
drug abuse <input type="checkbox"/>		
cancer <input type="checkbox"/>		
iICH <input type="checkbox"/>		
meningitis <input type="checkbox"/>		
hear, vision <input type="checkbox"/>		
vitamin def <input type="checkbox"/>		
brain image <input type="checkbox"/>		
Family Hx	Former medical/surgical history	
dementia <input type="checkbox"/>		
Parkinson's <input type="checkbox"/>		
depression <input type="checkbox"/>		
stroke <input type="checkbox"/>		
CAD <input type="checkbox"/>		
Down's <input type="checkbox"/>		
Diabetes <input type="checkbox"/>		
Psychiatric history		
Medications	<input type="checkbox"/> see list	
Positives (Family history, occupation, habits, function)		
Education _____ yrs.		
Employment _____		
metals		
ECT		
boxer		
Health Habits:		
Tobacco _____ pk-yrs.		
Alcohol _____ /day		
Driving		

Vital Signs		BP _____	P _____	T _____	Wt. _____ lb	Ht. _____ in		
Eyes	<input type="checkbox"/> nl conjunctiva & lids		MS Gait <input type="checkbox"/> nl gait & station Nails <input type="checkbox"/> no clubbing, cyanosis					
Pupils	<input type="checkbox"/> pupils symmetrical, reactive		Check nl, circ abn	ROM	Strength	Tone	abnormals	
Fundus	<input type="checkbox"/> nl discs & pos elements		Rt. Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ENT-External	<input type="checkbox"/> no scars, lesions, masses		Lt. Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Otoscopic	<input type="checkbox"/> nl canals & tympanic membranes		Rt. Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hearing	<input type="checkbox"/> nl to _____		Lt. Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Intranasal	<input type="checkbox"/> nl mucosa, septum, turbinate		Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ant. Oral	<input type="checkbox"/> nl lips, teeth, gums		Skin	<input type="checkbox"/> nl to inspection & palpation				
Oropharynx	<input type="checkbox"/> nl tongue, palate, pharynx		Neurologic	<input type="checkbox"/> nl alertness, attentive				
Neck palp.	<input type="checkbox"/> symmetrical without masses		Cranial nerves	<input type="checkbox"/> w/o gross deficit				
Thyroid	<input type="checkbox"/> no enlargement or tenderness		Coordination	<input type="checkbox"/> nl rapid alternating movement				
Resp. effort	<input type="checkbox"/> nl without retractions		DTR's	<input type="checkbox"/> symmetrical, _____ (scale: 0-4+)				
Chest percuss.	<input type="checkbox"/> no dullness or hyperresonance		Sensation	<input type="checkbox"/> nl touch, proprioception				
Chest palp.	<input type="checkbox"/> no fremitus		Psych	Orient'n	<input type="checkbox"/> nl to day, mo, yr, time, location _____ /10			
Auscultation	<input type="checkbox"/> nl bilateral breath sounds w/o rales		Registration	<input type="checkbox"/> register 3 items _____ /3				
Heart palp.	<input type="checkbox"/> nl location, size		Attn/Calc	<input type="checkbox"/> serial subtraction, world bckwd _____ /5				
Cardiac ausc.	<input type="checkbox"/> no murmur, gallop, or rub		Recall	<input type="checkbox"/> recall 3 items _____ /3				
Carotids	<input type="checkbox"/> nl intensity w/o bruit		Language	<input type="checkbox"/> nl nam'g, repit'n, compr'n, read'g, writ'g _____ /8				
Pedal pulses	<input type="checkbox"/> nl posterior tibial & dorsalis pedis		Visuospatial	<input type="checkbox"/> copy design, clock _____ /1				
Breasts	<input type="checkbox"/> nl inspection & palpation		Knowledge	<input type="checkbox"/> current/past presidents total: _____ /30				
Abdomen	<input type="checkbox"/> no masses or tenderness		Mood	<input type="checkbox"/> nl GDS _____ /15				
L/S	<input type="checkbox"/> no liver/spleen		Speech	<input type="checkbox"/> nl rate, volume				
Hernia	<input type="checkbox"/> no hernia identified		Thought cont.	<input type="checkbox"/> logical, coherent				
Anus/rectal	<input type="checkbox"/> no abnormality or masses		Psychosis	<input type="checkbox"/> no hallucinations, delusions				
GU male	<input type="checkbox"/> nl to inspection & palpation		Judgement	<input type="checkbox"/> nl				
Prostate	<input type="checkbox"/> nl size w/o nodularity		Behavior	<input type="checkbox"/> cooperative, appropriate				
GU female	<input type="checkbox"/> external genitalia nl w/o lesions		Hachinski sum 1 st column x 2; sum 2 nd column; total columns					
Int. inspection	<input type="checkbox"/> nl bladder, urethra, & vagina		Abrupt onset	<input type="checkbox"/>	Stepwise	<input type="checkbox"/>		
Cervix	<input type="checkbox"/> nl appearance w/o discharge		Hx stroke	<input type="checkbox"/>	Somatic	<input type="checkbox"/>		
Uterus	<input type="checkbox"/> nl size, position, w/o tenderness		Focal signs	<input type="checkbox"/>	Emotional	<input type="checkbox"/>		
Adnexa	<input type="checkbox"/> no masses or tenderness		"symptoms"	<input type="checkbox"/>	HTN	<input type="checkbox"/>		
Lymphatic	<input type="checkbox"/> nl neck & axillae		sum x2:	_____	sum:	_____	total: _____	
Lymph other	<input type="checkbox"/>							

Additional description of positive findings:

Preliminary Diagnostic Assessment (impairment level, comorbid health conditions, potential treatable elements)

Recommendations:

- Lab:
 - Electrolytes
 - CA
 - TSH
 - STS
 - B₁₂
- Imaging (type, hx)_____
- Medication changes
- Referrals
- Information
 - Medical Evaluation of Memory Loss
 - Treatments for AD
 - Stroke Prevention
 - Family Report: Caregiving Issues

Memory Loss Evaluation: Initial Visit

Date: _____

Age: _____

Fam Rpt: Beh

3=unable; 0=able

checkbook _____

taxes _____

shopping _____

games _____

stove _____

meal prep _____

events _____

TV, book _____

appointments _____

travel _____

score _____

Story of the Memory Problem

Record your version of the history of the dementing illness from the family questionnaire in Tools, pp.17-18, and your interview of the patient and caregiver.

Record scores here from the questionnaire in Tools, pp.13-14; scoring instructions are on p.15

Current medical history

Describe active problems with potential impact on cognitive function

ROS

circle positives

personality

speech

weakness

judgment

confusion

alertness

delusions

hallucinations

emotional

sensory

mouth

fall, injury

balance

snore

short of breath

cough

bowel

hematochezia

sex dysfxn

incontinence

joint pain

extremities

skin

appetite

thirst

fatigue

sleep

wt change

food

Past Med Hx

check positives

HTN

CAD

thyroid

cholesterol

CVA

neuropathy

periph vasc

diabetes

hepatitis

head injury

Parkinson's

alcohol

depression

VD

seizures

drug abuse

cancer

ICH

meningitis

hear, vision

vitamin def

Record information here from the review-of systems questions (pp.28-29) in the family questionnaire in Tools, pp. 19-29

Former medical/surgical history

Record information here from the questions on past medical history (p.21) in the family questionnaire in Tools, pp. 19-29

Psychiatric history

Record information here from questions on pp. 24, 26 in the family questionnaire in Tools, pp. 19-29

Medications

see list

Use the medication list (p.27) in the family questionnaire in Tools, pp. 19-29, or your own version

Education

_____ yrs.

Employment

metals

ECT

boxer

Health Habits:

Tobacco

_____ pk-ysrs

Alcohol

_____ /day

Positives (FHx, occup., habits, function)

Record information here from questions on p. 26 in the family questionnaire in Tools, pp. 19-29

Preliminary Diagnostic Assessment (Impairment level, comorbid health conditions, potential treatable elements)

Recommendations:

