St Johns Cognitive Health
555 East Broadway Ste. 229
PO Box 4010
Jackson Hole, Wyoming
Phone: (307) 739-7434
Fax: (307) 739-0914

St John's Medical Center

Pt Name:_____
DOB: _____
Visit Date: _____

GETTING TO KNOW YOU

1. What is the concern or reason for your visit today?_____

_____

_____

2. How did you learn about us? (circle one) Doctor Friend or Another Patient Community Agency

   Brochure or News Story Alzheimer's Association Internet Other:_____

3. Level of Education (circle one)

   Some Primary School High School Graduate Some College College Graduate Post-Graduate

4. Are you currently (circle one) Employed Retired Disabled

   Usual Occupation?_____

5. Where do you live? (circle one) House or Apartment Retirement Community

   Assisted Living Nursing Home Other:_____

6. Who do you live with? (circle one) Alone Spouse Partner Friend

   Relative Other (specify)_____

7. How often do you get out of the house?(circle one)

   Daily A Few Times a Week Once Per Week or Less

8. What do you do for exercise?_____

   How often do you exercise?_____

9. Do you drink alcohol? Yes / No If yes, how often? _____

   How much? _____

10. Do you currently use tobacco? Yes / No Packs/Cans per day _____

    For how many years? _____ Quit date? _____

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REVIEW OF SYSTEMS

NEUROLOGIC

1. Do you have headaches? ..... NO YES
2. Do you have trouble walking? ..... NO YES
3. Have you had falls? ..... NO YES
4. Have you ever lost consciousness? ..... NO YES
5. Have you ever had seizures, fits or convulsions? ..... NO YES
6. Have you ever had a stroke, TIA, or stroke warning? ..... NO YES
7. Do you have pain or numbness in your legs or arms? ..... NO YES
8. Do you have difficulty with sleep? ..... NO YES

BEHAVIORAL

9. Over the past 2 years have you lost interest or pleasure in doing things? ..... NO YES
10. Over the past 2 years have you ever felt sad, depressed or hopeless? ..... NO YES
11. Have you seen anything that others could not? ..... NO YES
12. Do you feel anxious or fearful? ..... NO YES

CONSTITUTIONAL

13. Have you gained more than 7 pounds in the last year? ..... NO YES
14. Have you lost more than 7 pounds in the last year? ..... NO YES
15. Have you had a fever recently? ..... NO YES

EYES

16. Do you have trouble with your vision or ever see double? ..... NO YES
17. Have you had an episode where you lost your vision for a while? ..... NO YES
18. Do you have trouble reading? ..... NO YES

EARS

19. Do you have trouble hearing? ..... NO YES
20. Do you have ringing or noises in your ears? ..... NO YES

NOSE, MOUTH AND THROAT

21. Do you choke or have difficulty swallowing? ..... NO YES

SKIN

22. Do you have skin problems or a change in a wart or mole? ..... NO YES

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BLOOD AND LYMPHATICS

23. Is there any swelling in your armpits or groin? ..... NO YES
24. Have you ever had anemia? ..... NO YES

RESPIRATORY

25. Do you get short of breath with exertion such as fast walking or climbing stairs? ..... NO YES
26. Do you ever wake up at night short of breath? ..... NO YES
27. Have you ever coughed up blood? ..... NO YES

CARDIOVASCULAR

28. Have you had high blood pressure? ..... NO YES
29. Have you had a heart attack, chest pain or tightness? ..... NO YES
30. Have you ever felt that you heart was thumping and/or racing? ..... NO YES
31. Has anyone ever told you that you have a heart murmur? ..... NO YES
32. Do you have swollen feet and/or ankles? ..... NO YES

GASTROINTESTINAL (GI)

33. Are you experiencing stomach pain? ..... NO YES
34. Do you have nausea or vomiting? ..... NO YES
35. Are your bowels ever loose for more than a day or two? ..... NO YES
36. Do you ever have difficulty controlling your bowels? ..... NO YES

GENITOURINARY (GU)

37. Are you ever unable to control your urine? ..... NO YES
38. Have you had bladder infection or blood in your urine? ..... NO YES

MUSCULOSKELETAL

39. Do you have trouble with muscle stiffness? ..... NO YES
40. Do you have pain or swelling in your joints? ..... NO YES
41. Do you have back pain? ..... NO YES

ENDOCRINE

42. Do you have Diabetes? ..... NO YES
43. Do you have thyroid problems? ..... NO YES

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MEDICATION LIST

Please list all the medications, prescription and non-prescription that you are taking currently or have been told to take. Include all nutritional supplements, laxatives, pain relievers, vitamins, ointments, home remedies, etc.

Medication Name	Dose	When You Take Them	Date Begun

ALLERGIES TO MEDICATION

[ ] None Known

[ ] I have an allergy to: _____

_____

RELATIVES WITH MEMORY PROBLEMS

[ ] None

[ ] Yes, Specify number and relationships: _____

_____

_____

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CHANGES IN YOUR DAILY LIFE (FAQ)

Please fill out this activity list by putting an X in the column that best describes your situation.

Activity	No Problem or never did, but could now.	Has difficulty, but does by self; or never did and would have difficulty now.	Needs assistance	Can't do
1. Writing checks, paying bills, balancing checkbooks.				
2. Assembling tax records, business affairs, or papers.				
3. Shopping alone for clothes, household necessities, or groceries.				
4. Playing a game of skill, working on a hobby.				
5. Heating water, making a cup of coffee, turning on the stove.				
6. Preparing a balanced meal.				
7. Keeping track of current events.				
8. Paying attention to, understanding, discussing TV, book, or magazine.				
9. Remembering appointments, family occasions, holidays, or medications.				
10. Traveling out of the neighborhood, driving, arranging to take the bus.				

LIST OF SURGERIES

Name of Surgery	Approximate Date or Year

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INITAIL MEMORY ASSESSMENT

GERIATRIC DEPRESSION SCALE

Please answer the following questions by circling "NO" or "YES".

1. Are you basically satisfied with your life? ..... **NO** YES
2. Have you dropped many of your activities and interests? ..... NO **YES**
3. Do you feel that your life is empty? ..... NO **YES**
4. Do you often get bored? .....NO **YES**
5. Are you in good spirits most of the time? ..... **NO** YES
6. Are you afraid that something bad is going to happen to you? .....NO **YES**
7. Do you feel happy most of the time? ..... **NO** YES
8. Do you often feel helplessness? ..... NO **YES**
9. Do you prefer to stay home, rather than go out and do new things? .....NO **YES**
10. Do you feel you have more problems with memory than most? .....NO **YES**
11. Do you think it is wonderful to be alive now? ..... **NO** YES
12. Do you feel pretty worthless the way you are now? .....NO **YES**
13. Do you feel full of energy? ..... **NO** YES
14. Do you feel your situation is hopeless? .....NO **YES**
15. Do you think that most people are better off than you? ..... NO **YES**