Center for Neurocognitive Disorders
1941 East Rd, Ste 4358
Houston, TX 77054
(713) 486-0500

UTHealth
The University of Texas
Health Science Center at Houston

Dear Sir/Madam:

Thank you for choosing the Center of Neurocognitive Disorders for your healthcare needs. We at UTHealth, and its affiliates (Memorial Hermann Hospital and the Mischer Neuroscience Institute), work to provide excellent, cutting-edge patient care, research, and teach the next generation of physicians. We look forward to working with you.

Sincerely,

Paul E. Schulz, MD
Professor and Vice Chair of Neurology for Quality Assurance
Director, Memory Disorders and Dementia Clinics
The University of Texas Health Science Center at Houston
The Mischer Neuroscience Institute and Memorial Hermann Hospital

A. EDUCATION

One of our missions is to train future medical personnel, as a result our physicians may have medical trainees, such as medical students and residents, accompany them during clinic hours. Thank you for allowing them to see you during the appointment, as you greatly assists the training of the next generation's experts.

B. CONSULTING

Our evaluation process will usually require multiple visits. We are setup with a consulting model as opposed to long term care. Our initial visit will be used to establish the patient's main concern and order the proper testing. We may use one of several diagnostic tools, such as Brain MRIs, blood work, neuropsychological testing, and PET scans. After receiving the results of the initial tests, we will schedule a follow up appointment to finalize our assessment and recommend a treatment plan. We ask that all of our patients are accompanied by a family member or anyone else who can help provide us with any additional information about the patient's chief complaint.

Please keep in mind that we are typically a consulting service. Upon completion of the diagnostic process and formulation of a treatment, we will inform your referring physician of our plan, so they can continue your care. If you do not have a referring physician, we are more than happy to help you find one with whom you are comfortable.

C. PRESCRIPTION REFILLS

Upon formulation of the treatment plan, we will prescribe the appropriate medications with more than enough refills to last you until your next appointment. Please do not lose your prescriptions as it is very difficult for us to provide another copy. We typically do not prescribe refills without seeing you. Upon completion of your consultation with us, it will be the referring physician's responsibility to refill your prescriptions. We will communicate with the physician's office directly to inform them of the medications.

D. RESEARCH

To provide our patients the best possible care, we are continually collaborating with experts from around the world to improve the diagnoses, treatment, and prevention of cognitive disorders. This is only possible with the support of our patients, which can include something as simple as answering brief questionnaires or giving blood samples for analysis, or something more complex like a multi-year trial. Our physicians and research coordinators are happy to fully address any concerns you might have about participation in research.

E. COMMUNICATION

The UT Physicians call center will call you to set up an appointment time for your initial visit. It will be difficult to reach our office as our staff spends most of their time assisting patients in person, providing them with instructions, writing orders, filling prescriptions, and scheduling tests. During this time, it is difficult to receive phone calls out of respect for your time and attention. For this reason, please pay careful attention to the instructions provided to you during our appointment time.

We kindly request that calls to the office be kept to a minimum. Medical questions can be saved for a future appointment or emergencies should be directed to the referring physician immediately. Given we are a busy consulting service, constantly evaluating new patients, we may not be able to address your concern over the phone. Symptoms can be discussed in person at your next appointment. If you are experiencing a medical emergency, please go to the Emergency Department.

F. Patient Questionnaire

PATIENT CONTACT INFORMATION	
Full Name:	Date of Birth:
Home Address:	
Home Phone:	Cell Phone:
Email Address:	Fax:
Gender:	Race:
Insurance Related Information:	
Reason for Visit:	
FAMILY MEMBER/CAREGIVER CONTACT INFORMATION	
Full Name:	Relationship to Patient:
Home Address:	
Work Address:	
Work Phone:	Cell Phone:
Email Address:	Fax:
REFERRING MD	
Full Name:	
Address:	
Phone Number:	Fax:

PATIENT HEALTH INFORMATION			
MEMORY	Memory Loss	☐ Yes	☐ No
	Transient Memory Loss	☐ Yes	☐ No
	Sustained Memory Loss	☐ Yes	☐ No
	Impaired Long-Term Memory	☐ Yes	☐ No
	Impaired Short-Term Memory	☐ Yes	☐ No
	Impaired Memory of Past Events	☐ Yes	☐ No
	Inability to Form New Memories	☐ Yes	☐ No
	Impaired Learning Ability	☐ Yes	☐ No
	Percentage of Recall Daily Activities	%	
	Cannot Recall Phone Numbers	☐ Yes	☐ No
	Confusion Recalling Names	☐ Yes	☐ No
	Asks the Same Question Repeatedly	☐ Yes	☐ No
	Difficulty Performing Familiar Tasks	☐ Yes	☐ No
	Awareness of Memory Impairment	☐ Yes	☐ No

LANGUAGE	Reduced General Fund of Knowledge	☐ Yes	☐ No
	Difficulty Finding Desired Words	☐ Yes	☐ No
	Frequency ☐Every sentence ☐Few times per day ☐Once per week		
	Difficulty Understanding Others as They Speak	☐ Yes	☐ No
	Difficulty Writing	☐ Yes	☐ No
	Difficulty Reading	☐ Yes	☐ No
VISUOSPATIAL	Difficulties Getting Lost	☐ Yes	☐ No
	Confused in Finding Someplace	☐ Yes	☐ No
	Lost in Unfamiliar Areas	☐ Yes	☐ No
	Lost in Familiar Neighborhoods	☐ Yes	☐ No
	Gets Lost Finding Particular Room in Your House	☐ Yes	☐ No
ORIENTATION	Difficulties Recalling: ☐Day of the week ☐Date in month ☐Month ☐Year		
	Difficulties Recalling Location	☐ Yes	☐ No
	Difficulties Recalling Names	☐ Yes	☐ No
ATTENTION	Difficulties Maintaining Attention on a Task as Compared to Past	☐ Yes	☐ No
	Difficulty Following a Television Show	☐ Yes	☐ No
	Do Paragraphs Have to be Re-read	☐ Yes	☐ No
CALCULATIONS	Unable to Balance Checkbook	☐ Yes	☐ No
	Do you have problems balancing your own checkbook?	☐ Yes	☐ No
	Unable to Give Correct Dollars When Paying Grocers	☐ Yes	☐ No
	Unable to Calculate Tip at a Restaurant	☐ Yes	☐ No
ACTIVITIES OF DAILY LIVING (ADLs)	Unable to Cook as Well as in the Past	☐ Yes	☐ No
	Complexity of Meals	1 2 3 4 5 6 7 8 9 10	
	Difficulty Feeding Oneself	☐ Yes	☐ No
	Difficulty Picking Out Own Clothes	☐ Yes	☐ No
	Unable to Use the Remote Control for TV	☐ Yes	☐ No
	Unable to Load and Use a Dishwasher	☐ Yes	☐ No
	Unable to Manage One's Own Medications	☐ Yes	☐ No
	Changes in Hobby Involvement	☐ Yes	☐ No
	Unable to Drive	☐ Yes	☐ No
	Not Driving in the City	☐ Yes	☐ No
	Recent Accidents	☐ Yes	☐ No
	Difficulty Grooming	☐ Yes	☐ No
	Difficulty Bathing	☐ Yes	☐ No

	Difficulty Dressing Oneself	☐ Yes	☐ No
	Unable to Use The Telephone By Oneself	☐ Yes	☐ No
	Unable to Use a Vacuum Cleaner	☐ Yes	☐ No
	Unable to Do One's Own Shopping	☐ Yes	☐ No
	Unable to Do One's Own Housekeeping Work	☐ Yes	☐ No
MOOD/AFFECT	Depressed	☐ Yes	☐ No
	Anxious	☐ Yes	☐ No
	Recent Change in Weight Weight Gain lbs Weight Loss lbs	☐ Yes	☐ No
	Change in Appetite	☐ Yes	☐ No
	Change in Sleep Patterns	☐ Yes	☐ No
	Change in Interest in Sexual Activity	☐ Yes	☐ No
	Feelings of Sadness	☐ Yes	☐ No
	Thoughts About Suicide	☐ Yes	☐ No
PERSONALITY	Change in Personality	☐ Yes	☐ No
	Decreased Tolerance for Frustration	☐ Yes	☐ No
	Patient Less Bothered by Things Going on Around You	☐ Yes	☐ No
BEHAVIORAL	Change in Behavior	☐ Yes	☐ No
	Off-Color Joking or Suggestive Comments	☐ Yes	☐ No
	Stereotyping	☐ Yes	☐ No
	Spent or Invested Money in an Atypical Way	☐ Yes	☐ No
	Change in Judgment	☐ Yes	☐ No
	Any Agitation	☐ Yes	☐ No
	Demonstrated Aggressive Actions	☐ Yes	☐ No
HALLUCINATIONS/	Auditory Hallucination	☐ Yes	☐ No
DELUSIONS/	Visual Hallucination	☐ Yes	☐ No
ILLUSIONS	Description of Hallucination		
	Friendly Hallucinations	☐ Yes	☐ No
	Frightening Hallucinations	☐ Yes	☐ No
	Hearing Things Different Than Normal	☐ Yes	☐ No
	Seeing Things Different Than Normal	☐ Yes	☐ No
	Concerned About People Taking Things	☐ Yes	☐ No
	Illusion	☐ Yes	☐ No
VASCULAR SYMPTOMS	Previously diagnosed with Stroke	☐ Yes	☐ No

	Which side of your body, if any, was involved?	☐ N/A	☐ Right	☐ Left
	Stroke symptoms that have worried you about the possibility of a stroke		☐ Yes	☐ No
	Taking medications to prevent stroke		☐ Yes	☐ No
	Long-lasting episodes of weakness on one side of your body?		☐ Yes	☐ No
	Long-lasting episodes of numbness		☐ Yes	☐ No
	Loss of Vision		☐ Yes	☐ No
	Seeing Double		☐ Yes	☐ No
	Problems Feeling One Side of Face		☐ Yes	☐ No
	Difficulties Speaking		☐ Yes	☐ No
	Difficulties Swallowing		☐ Yes	☐ No
	Problems Hearing or Localized Sounds		☐ Yes	☐ No
	Problems with Balance		☐ Yes	☐ No
	Problems with Vertigo		☐ Yes	☐ No
	Problems with Dizziness		☐ Yes	☐ No
	Heart Attack		☐ Yes	☐ No
	Irregular Heart Beat		☐ Yes	☐ No
	Hypertension		☐ Yes	☐ No
	Elevated Cholesterol or Triglycerides		☐ Yes	☐ No
	Diabetes Mellitus		☐ Yes	☐ No
	Peripheral Vascular Disease			
STRENGTH	Decreasing Muscle Mass		☐ Yes	☐ No
	Muscles Jumping		☐ Yes	☐ No
	Muscle Weakness		☐ Yes	☐ No
EXTRAPYRAMIDAL	Change in Walking		☐ Yes	☐ No
	Walking Changed		Date:	
	Difficulty with Balance		☐ Yes	☐ No
	Arthritis Impacting Walking		☐ Yes	☐ No
	Falls While Walking		☐ Yes	☐ No
	Developed Tremors		☐ Yes	☐ No
	Neck Stiffness		☐ Yes	☐ No
WORK-UP	Have you had an MRI of your brain or spinal cord? Please bring a CD of any imaging with you to our appointment.		☐ Yes	☐ No
	Date:	Location:		
	Have you had neuropsychological testing? If so, please bring those results to our appointment.		☐ Yes	☐ No

	Have you had blood-work to evaluate your thinking difficulties? If so, please bring copies of the results to our appointment.	☐ Yes	☐ No
	Have you had an electroencephalogram (an EEG)?	☐ Yes	☐ No
	Have you had a SPECT scan or a PET scan? If so, please bring the results and the images on a CD to our meeting?	☐ Yes	☐ No
	Have you had a spinal tap (a lumbar puncture)?	☐ Yes	☐ No
TREATMENTS	Have you had any treatments for your thinking difficulties? This might have included things like donepezil (Aricept), rivastigmine (Exelon), galantamine (Reminyl), memantine (Namenda), Tacrine (Cognex), Vitamin E, Vitamin C, etc…	☐ Yes	☐ No
	Have you had any medications for your mood, such as antidepressants or anti-anxiety medications?	☐ Yes	☐ No
PAST MEDICAL HISTORY	List any medical problems or conditions you have currently or in the past:		

Have you been diagnosed with or been treated for any of the following?

☐ Hypertension

☐ Diabetes

☐ Obesity

☐ Tobacco use

☐ Alcoholism

☐ Stroke

☐ Heart attacks

SURGERIES		
Type:	Date:	Hospital:

OTHER HOSPITALIZATIONS		
Reason:	Date:	Hospital:

MEDICATIONS	**Please list your prescribed drugs and over-the-counter drugs, the size pill (dosage), the frequency with which you are taking it, and the date that you started it.**		
Name of Medication:	Dosage:	Frequency & Time of Administration:	Date you started medication:
ALLERGIES TO MEDICATIONS			
Name of Drug:	Reaction You Had:		

REVIEW OF SYSTEMS		
Constitutional		
☐Recent Weight Gain	☐Feeling Poorly	☐Fever
☐Recent Weight Loss	☐Tired (fatigue)	☐Chills
Eyes		
☐Eye Pain	☐Drooping Eyelids	☐Blurry Vision
☐Red Eyes	☐Dry Eyes	☐Eyesight Problems
☐Loss of Vision	☐Itchy Eyes	☐Discharge from Eyes
Ear, Nose, and Throat (ENT)		
☐Nosebleeds	☐Earache	☐Sore Throat
☐Nasal Discharge	☐Loss of Hearing	☐Hoarseness
	☐Tinnitus	
Cardiovascular		
☐Chest Pain	☐Fast Heart Rate	☐Leg Pain
☐Palpitations	☐Slow Heart Rate	☐Lower Leg Swelling
Respiratory		
☐Shortness of Breath	☐Cough	☐Short Breath Lying Down
☐Wheezing	☐ Shortness of Breath on Exertion	☐Paroxysmal Nocturnal Dyspnea (PND)
Sleep		
☐Obstructive Sleep Apnea	☐Snoring	☐Insomnia
☐Apnea		
Gastrointestinal		
☐Abdominal Pain	☐Constipation	☐Heartburn
☐Vomiting	☐Diarrhea	☐Black or Tarry Stools
☐Nausea	☐Trouble Swallowing	☐Bowel Incontinence
Genitourinary – Female		
☐Painful Urination	☐Pelvic Pain	☐Vaginal Discharge
☐Urinary Incontinence	☐Painful Menstruation	☐Abnormal Vaginal Bleeding
☐Urgency	☐Frequency	☐Lack of Sex Drive
Genitourinary – Male		
☐Painful Urination	☐Hesitancy	☐Genital Lesion
☐Urinary Incontinence	☐Nighttime Urination	☐Testicular Pain
☐Urgency	☐Frequency	☐Lack of Sex Drive
☐Impotence		
Musculoskeletal		
☐Joint Pain	☐Joint Swelling	☐Joint Stiffness
☐Limb Pain	☐Limb Swelling	☐Sciatica
☐Neck Pain	☐Back Pain	☐Muscle Cramps
Integumentary		

☐Skin Lesions	☐Itching	☐Dry Skin
☐Skin Wound	☐Change in a Mole	☐An Unusual Growth
Neurological/Cognitive		
☐Confused or Disoriented	☐ Decreased Concentrating Ability	☐Changed Thought Patterns
☐Memory Lapses/Loss	☐Difficulties in Speech	☐Repeating Questions
☐ Exag/Inapp Emotional Outburst		
Motor		
☐Facial Weakness	☐Arm Weakness	☐Hand Weakness
☐Leg Weakness	☐Poor Coordination	☐Difficulty Writing
☐Tremor		
Sensory		
☐No Sensation	☐Numbness	☐Tingling
☐Burning Sensation	☐Hyperesthesia	
General		
☐Seizures	☐Cluster Headache	☐Fainting
☐Vertigo	☐Migraine Headache	☐Lightheadedness
☐Dizziness	☐Tension Headache	☐General Headache
Gait		
☐Difficulty Walking	☐Inability to Walk	☐Ataxia
☐Frequent Falls	☐Limping	
Psychiatric		
☐Suicidal	☐Anxiety	☐Change in Personality
☐Sleep Disturbances	☐Depression	☐Emotional Problems
Endocrine		
☐Protruding Eyes	☐Muscle Weakness	☐Feelings of Weakness
☐Hot Flashes	☐Deepening of the Voice	
Heme/Lymph		
☐Easy Bleeding	☐Swollen Glands	☐Swollen Glands in the Neck
☐Easy Bruising		

SOCIAL HISTORY			
Date of Birth:			
Birthplace:			
Marital Status:			
Do you live with your spouse?	☐N/A	☐ Yes	☐ No
Highest Education Level:			
Are you working? ☐Yes ☐No Occupation:			
Did you retire?		☐ Yes	☐ No
Handedness: ☐Right ☐Left			

Habits:			
Alcohol Use			
☐None	☐Up to 2 drinks per day	☐More than 2 drinks per day	
Did you ever have a problem with drinking too much?		☐ Yes	☐ No
Cigarette, Pipe, or Cigar Use			
☐Never Smoked	☐Current Smoker	☐Previous Smoker	
☐Recreational Drug Use			
Did you ever use illicit drugs, such as marijuana, cocaine, heroin, etc…?		☐ Yes	☐ No
Type of Drug:	When:	How much:	
☐Never Used	☐Current User	☐Previous User	

FAMILY HISTORY		
Please check if you have a family history of:		
☐High Blood Pressure	☐Alzheimer's Disease	☐Stroke
☐Multiple Sclerosis	☐Diabetes	☐ Parkinson's disease
☐Heart Disease	☐Epilepsy	☐Weakness

Please indicate whether your relatives are alive or deceased, what illnesses they have or had, and the disease from which they might have died. If anyone in your family had neurologic difficulties or any problems with thinking or memory, please list the persons and their difficulties.

Relative:	**Name:**	**Status of Life:**		**Neurologic Illnesses**	**Other Illnesses:**
Maternal Grandmother		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s): Age of Onset:	
Maternal Grandfather		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Paternal Grandmother		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Paternal Grandfather		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	

Mother		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Father		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Aunts:		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Uncles:		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	

		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Siblings:		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset::	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	List and Age of Onset:	
		☐ Alive Age::	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Children:		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive	☐ Deceased	Type(s) and Age	

		Age:	Age at Death: Cause of Death:	of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset::	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Grandchildren:		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	

		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		☐ Alive Age:	☐ Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	