Questionnaire for PATIENTS

Thank you for agreeing to fill out the following questionnaire. This document should be filled out by you, to the best of your ability; NOT by a healthcare professional. Your answers to these questions will help guide our assessment, Do not worry if you forget something or cannot fill out a certain question. If you have any questions or concerns, we will try our best to address them during the appointment. Please note the time you start and finish the questionnaire. Thank you.

Part 1: Please list ALL the medications and supplements that you take regularly:

Do you have any allergies? YES_____NO_____

Please list any allergies: _____

1. **Have you ever smoked cigarettes?** YES_____NO_____
   If so, for how long? _____
2. **Do you currently drink alcohol?** YES_____NO_____
   If so, how much per week? _____
3. **Did you ever drink alcohol?** YES_____NO_____
   When did you stop? _____
4. **Do you currently use recreational drugs (such as marijuana)?**
   YES_____NO_____

Part 2:

1. **Has there been a change in your ability to do your day-to-day tasks?**
   YES_____NO_____

2. **Do you need help with any of the following tasks?**
   - **a.** Managing money/bills YES_____NO_____
   - **b.** Taking medications YES_____NO_____
   - **c.** Transportation/driving YES_____NO_____
   - **d.** Preparing meals YES_____NO_____
   - **e.** Cleaning the house YES_____NO_____
   - **f.** Using the telephone and/or computer YES_____NO_____

3. **Do you need help with any of the following tasks?**
   - **a.** Bathing? YES_____NO_____
   - **b.** Dressing/grooming? YES_____NO_____
   - **c.** Using the toilet? YES_____NO_____
   - **d.** Eating meals? YES_____NO_____
   - **e.** Going up/down stairs? YES_____NO_____

4. **Do you use a cane or a walker?** YES_____NO_____

5. **Does anybody help you at home?** YES_____NO_____

6. **Do you have any of the following in your home?**
   - **a.** Grab bars in the bathroom YES_____NO_____
   - **b.** Raised toilet seat YES_____NO_____
   - **c.** Bath chair YES_____NO_____

7. **Do you have a power of attorney for personal care?**
   YES_____NO_____
   - **a.** If yes, who is that person? _____

Part 3:

1. **Have you ever:**
   - **a. Left the stove on accidentally?** YES_____NO_____
   - **b. Left the tap on accidentally?** YES_____NO_____
   - **c. Gotten lost?** YES_____NO_____

2. **Do you have concerns about your memory?** YES_____NO_____

3. **In the last month:**
   - **a. Have you felt down, depressed, or blue?** YES_____NO_____
   - **b. Have you lost interest or pleasure in doing things?**
     YES_____NO_____

4. **Do you feel rested when you wake up in the morning?**
   YES_____NO_____

5. **Do you nap during the day?** YES_____NO_____

6. **Do you ever fall asleep watching TV or listening to a conversation?**
   YES_____NO_____

7. **Have you fallen down in the last year?** YES_____NO_____

8. **Do you have problems with your vision?** YES_____NO_____

9. **Do you wear glasses?** YES_____NO_____
   a. **When was the last time you had your vision assessed?**
      _____

10. **Do you have problems with your hearing?** YES / NO
    a. **Have you ever been assessed for hearing aids?**
       YES_____NO_____

11. **Do you have difficulty:**
    a. **Holding in urine?** YES_____NO_____
    b. **Holding in a stool?** YES_____NO_____
    c. **Making it to the toilet on time?** YES_____NO_____
    d. **Passing a bowel movement?** YES_____NO_____

12. **Have you lost any weight recently?** YES_____NO_____

13. **Do you have trouble eating or swallowing?** YES_____NO_____

14. **Do you have any problems with your skin?** YES_____NO_____

15. **Do you have problems with aches and pains?** YES_____NO_____
    a. **If yes, where does it hurt?** _____

Part 4:

1. **Does anyone in the family have any of the following?**
   a. **Dementia?** YES_____NO_____ **If so, who?** _____
   b. **Parkinson's disease?** YES_____NO_____
      If so, who? _____
   c. **Depression/mental health problems?** YES_____NO_____
      If so, who? _____

How long did it take you to fill out this questionnaire? _____