PET/CT Amyloid Brain Neuro Questionnaire

PET/CT POL.002  Effective Date: April 5, 2013

Patient Name: ____________________________  Todays Date: __________

☐ Female  ☐ Male  MRN#____________________  Age:__________________

What symptoms are you having? ____________________________

If none, do you know why your doctor ordered this exam? ____________________________

Has your doctor told you that he suspects you may have Alzheimer’s?  ☐ Yes  ☐ No  ☐ Possibly  ☐ Not sure what doctor thinks

Has your doctor told you that you have MCI (mild cognitive impairment), but not yet Alzheimer’s?  ☐ Yes  ☐ No  ☐ Not sure

Does your doctor suspect dementia, but is unsure if it is Alzheimer’s?  ☐ Yes  ☐ No  ☐ Not sure

Please indicate if you have or have had any of the following:

Memory Loss  ☐ Yes  ☐ No

*How long have you had memory loss? ________

* Would you consider your memory loss to be:  ☐ Mild  ☐ Moderate  ☐ Severe

* Has your memory loss progressed:  ☐ Slowly  ☐ Fast  ☐ Not much change over time

  *Difficulty remembering where you are?  ☐ Frequently  ☐ Sometimes  ☐ Almost never

  *Difficulty remembering names or finding words?  ☐ Frequently  ☐ Sometimes  ☐ Almost never

  *Difficulty remembering the date?  ☐ Frequently  ☐ Sometimes  ☐ Almost never

  *Confusion  ☐ Frequently  ☐ Sometimes  ☐ Almost never

Do you shower, dress, & cook on your own?  ☐ Yes  ☐ No, I have a helper for those things

Do you manage your own finances?  ☐ Yes  ☐ No, I have a helper for that

Do you still drive a car on your own?  ☐ Yes  ☐ No

Do you lose things frequently?  ☐ Yes  ☐ No

Have you ever had a stroke?  ☐ Yes  ☐ No

History of TIA (transient ischemic attack)?  ☐ Yes  ☐ No

Parkinson’s disease  ☐ Yes  ☐ No

Numbness  ☐ Yes  ☐ No  If yes, to what part of the body? ________  ☐ Left  ☐ Right

Localized Weakness  ☐ Yes  ☐ No  If yes, to what part of the body? ________  ☐ Left  ☐ Right

Paralysis  ☐ Yes  ☐ No  If yes, to what part of the body? ________  ☐ Left  ☐ Right

Slurred Speech  ☐ Yes  ☐ No

Loss of Balance  ☐ Yes  ☐ No

Difficulty Walking  ☐ Yes  ☐ No

Do you have a history of cancer?  ☐ Yes  ☐ No  If yes, what type? ________

If yes, has cancer spread to other areas in body?  ☐ Yes  ☐ No  If yes, to where? ________

Radiation treatment?  ☐ Yes  ☐ No  ☐ Not applicable  If yes, date of last treatment? ________ To what body part? ________

Chemotherapy?  ☐ Yes  ☐ No  ☐ Not applicable  If yes, date of last treatment: ________