School of Medicine & Health Sciences
THE GEORGE WASHINGTON UNIVERSITY

Memory Clinic New Patient Form

Patient Information

First Name: _____ **Last Name**: _____

Phone Number: _____ **Email Address:** _____

Gender: ☐ Man ☐ Woman ☐ Nonbinary **Birthdate:** _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Other **Veteran or Active Service**: ☐ Yes ☐ No

Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Other

Current/Previous Occupation: _____ **Do you Drive?** ☐ Yes ☐ No

Do you have: Medicare? ☐ Yes ☐ No **Medicaid?** ☐ Yes ☐ No **Other Insurance?** ☐ Yes ☐ No

Who referred you to Memory Clinic? ☐ Self ☐ Healthcare Provider ☐ Family Member ☐ Other

Name of Referring Person and Contact if other than self: _____

What County or Ward do you Live in? _____

Highest Education Level Completed: _____

Who lives in your household and what is their relation to you? _____

_____

Visit Information

What are your memory concerns?

_____

_____

_____

Who is coming to the appointment with you? _____

Medical History

Primary Care Provider: _____ **Number of Primary Care Provider:** _____

Do you have any allergies? ☐ Yes ☐ No **If so, please list:** _____

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Medical History

Do you have any of the following conditions?

- ☐ Diabetes Mellitus
- ☐ Hypertension
- ☐ Prior Stroke
- ☐ Vision loss
- ☐ Chronic Arthritis
- ☐ Prior Heart Disease
- ☐ Atrial Fibrillation
- ☐ Cardiac Arrhythmia
- ☐ Parkinson's Disease/Movement Disorder
- ☐ Osteoporosis
- ☐ Depression
- ☐ Anxiety
- ☐ Hearing loss

Do you have a previous diagnosis of Dementia, Mild Cognitive Impairment, or Memory Loss? ☐ Yes ☐ No

If yes, when and where were you diagnosed? _____

Have you ever been hospitalized, or have you ever had an operation? ☐ Yes ☐ No

If yes, please indicate the date, hospital, and reason: _____

_____

_____

Were you ever injured due to a fall? ☐ Yes ☐ No

What caused the fall and your injury? _____

_____

_____

Have you ever had a concussion, injury with loss of consciousness, traumatic brain injury, or bleeding in your brain?

☐ Yes ☐ No **Describe if able:** _____

How many hours do you sleep each night? _____ **Do you wake up feeling rested?** ☐ Yes ☐ No

Do you have any known sleep disorders? ☐ Yes ☐ No **If yes, please list:** _____

Have you ever had a sleep study? ☐ Yes ☐ No

If this was positive, what diagnosis were you given? _____

Have you ever smoked? ☐ Yes ☐ No **Do you presently smoke?** ☐ Yes ☐ No **If so, how much?** _____

Have you ever consumed alcoholic beverages? ☐ Yes ☐ No **Do you presently drink alcohol?** ☐ Yes ☐ No

If so, what and how much? _____

If you use any recreational drugs, please notify a member of the Memory Care Team.

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Is your family medical history notable for any major health conditions (i.e. stroke, diabetes, heart disease, cancer, Parkinson's disease, Alzheimer's disease, other memory disorders, seizures, etc.)? If yes, please list:

_____

_____

_____

Do you have an Advance Directive? ☐ Yes ☐ No **If yes, please bring a copy to your visit.**

Have you ever been a caregiver for someone with memory loss? ☐ Yes ☐ No **If yes, who?** _____

List all medications including over the counter and supplements. Bring all medications to your visit.

Drug Name	Dose & Frequency	Reason/Indication