CMA The Center For Memory and Aging

Family/Friend Informant Questionnaire

Thinking back 5 or more years, please fill out the following information as completely as possible :

1. How many years of education did the patient have total?

   ☐ High School (12) ☐ Some College (14) ☐ College (16) ☐ Post Graduate (20)

2. Briefly describe the memory problem. Starting when, progressive or not, and also talk about losing glasses, repeating self, etc.

   _____

   _____

   _____

   _____

   _____

3. Disorientation: Please DESCRIBE specific details

   ☐ Date / Time _____

   ☐ Place _____

   ☐ Forgetting the purpose / reason_____

   ☐ Repeating actions / phrases _____

4. Setting:

   ☐ Wandering _____

   ☐ Getting lost in a familiar setting _____

   ☐ Misplacing common items _____

   ☐ Trouble retracing last steps taken _____

5. Language:

   ☐ Speaking problems (finding right word) _____

   ☐ Speaking problems (revert to first language) _____

   ☐ Problem understanding people_____

   ☐ Keeping conversation _____

   ☐ Following simple instructions (1-2 step)_____

6. Gastrointestinal:

   Incontinence ☐ Bowel ☐ Urine _____

   ☐ Loss of appetite _____

   ☐ Weight loss (>5 lbs.) _____

7. Behaviors: Please describe

☐ Agitation _____

☐ Delusions _____

☐ Depression _____

☐ Frustration _____

☐ Hearing voices _____

☐ Paranoia _____

☐ Seeing things _____

☐ Sleeping problem _____

8. Describe any loss of daily function.

☐ Problems balancing checkbook _____

☐ Dressing themselves _____

☐ Running errands _____

☐ Bathing _____

☐ Grooming _____

☐ Shopping _____

☐ Cooking _____

☐ Cleaning _____

☐ Driving _____

☐ Using appliances_____

☐ Writing _____

☐ Keeping appointments _____

☐ Not going out of the house _____

9. Is s/he able to use a:

☐ Cell Phone	☐ Television	☐ Computer / laptop / tablet device	☐ DVD or VCR
☐ Vacuum Cleaner	☐ Washer/Dryer	☐ Dishwasher	☐ Checkbook
☐ Oven / Stovetop	☐ Microwave	☐ Coffee maker	☐ Car

If you have noticed a decline in their ability to use any of the above appliances, please describe the decline:

_____

_____

_____

Person Completing this Form: _____ Relationship to Patient:_____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Email address: _____