Alzheimer's Quality Initiative

Patient name: _____

Informant(s):

- Name _____ - Relationship to patient_____
- Phone number:_____ - Duration of relationship_____

Date of last visit: _____

Since last visit:

New medical event, hospitalization: ____Yes ____No

If yes, describe: _____

Over last month or so:

Visual hallucinations?	____Yes	____No
Odd ideas (delusions)?	____Yes	____No
Change in personality?	____Yes	____No
Depression?	____Yes	____No
Anxiety?	____Yes	____No
Loss of interest?	____Yes	____No
Withdrawal?	____Yes	____No
Loss of social graces?	____Yes	____No
Rudeness?	____Yes	____No
Inappropriate behavior?	____Yes	____No
Decreased speech?	____Yes	____No
Problems naming?	____Yes	____No
Obsessive behavior?	____Yes	____No
Refuse to cooperate?	____Yes	____No
Resist care?	____Yes	____No
Hard to handle?	____Yes	____No
Stubborn?	____Yes	____No
Get upset?	____Yes	____No
Have outbursts?	____Yes	____No
Rapid changes in mood?	____Yes	____No
Irritability?	____Yes	____No
Speaking too loud?	____Yes	____No
Yelling or cursing?	____Yes	____No
Physical aggression?	____Yes	____No
Nighttime problems?	____Yes	____No
Sleeping during day?	____Yes	____No
Appetite/eating changes?	____Yes	____No

Errors or not doing finances?	____Yes	____No
Errors with tips?	____Yes	____No
Errors with appointments?	____Yes	____No
Errors with medications?	____Yes	____No
Errors with electronic devices?	____Yes	____No
Getting lost?	____Yes	____No
Problems preparing food?	____Yes	____No
Problems dressing self?	____Yes	____No
Problems bathing?	____Yes	____No
Problems brushing teeth?	____Yes	____No
Problems with hobby/activity?	____Yes	____No
Problems shopping alone?	____Yes	____No
Errors driving?	____Yes	____No
	____N/A, not driving	
Making bad decisions?	____Yes	____No
Living will in place?	____Yes	____No

Who makes medical decisions for patient?

Help needed for caregiver? Circle:

Supervising? Day care?
Cleaning? Home care?
Getting time alone? Memory care?
No needs, willing and able to take over functions?

What is MOST problematic symptom? _____