



CHINESE HOSPITAL & UCSF MEMORY AND AGING CENTER
Memory Clinic Collaboration

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Intake Information Completed by _____ Date _____

Name of informant for this form _____

Relationship to patient _____ Contact Number _____

Personal Information

Patient's name _____ Date of birth _____

Gender: F M

Address _____

Telephone _____ Social Security Number _____

Ethnicity _____ Primary language _____

Country of birth _____ Immigrated from _____ Year _____

Insurance status: None(uninsured) Medical/Medicaid Private insurance

ID No: _____ Insurance Co. _____

ID. No. _____

Medical Information

Primary MD Name _____

Address _____

Telephone No. _____

Reason for referral: _____

(i.e. memory loss and/or other cognitive changes, behavior/personality changes, movement problems, need for diagnosis)

Has the patient been evaluated for memory loss in the past? Yes No DK

Has the patient had a brain scan in the past? Yes No DK

If yes, when? _____ What type? CT MRI DK

Where was it done? _____

Current health complaints?

Medical conditions (circle all that apply)

Stroke / Diabetes / Cancer / Thyroid problems / Hypertension / Depression

Medical history (includes major illnesses, recent hospitalizations, surgeries)

Has the patient ever had a head injury? Yes No DK

Ever lost consciousness? Yes No DK

Medications (list all, including over the counter and herbal preparations)

- | | |
|----|-----|
| 1. | 7. |
| 2. | 8. |
| 3. | 9. |
| 4. | 10. |
| 5. | 11. |
| 6. | 12. |

Family and Social Information

Marital status: Single / Married / Widowed / Divorced

Living arrangement

- | | |
|--|--|
| <input type="checkbox"/> Lives alone | <input type="checkbox"/> Lives in household with non-relatives |
| <input type="checkbox"/> Lives with spouse | <input type="checkbox"/> Lives in health-related facility |
| <input type="checkbox"/> Lives in household with relatives | <input type="checkbox"/> Lives in group setting other than health facility |

Years of education _____ Occupation/Work History _____