



DATABASE QUESTIONNAIRE

INSTRUCTIONS – 2008 forMemory Database Questionnaire

This questionnaire is for people of any age who are concerned about their memory and thinking. If you do not believe you have problems with memory and thinking, please do not answer this questionnaire. You can answer this questionnaire whether or not you have discussed your memory loss with your doctor.

You may need to collect information from pill bottles, medical records, calendars or even from family members to answer these questions. It's okay to have a family member or friend help you fill out the questionnaire.

Many of the questions in this document will not apply to you – please leave those questions blank.

We estimate it will take you 30 minutes to 2 hours to complete this questionnaire, depending on the number of medications and supplements you take, and how organized your medical records are.

PLEASE DO NOT PUT YOUR NAME, ADDRESS, PHONE NUMBER OR EMAIL ADDRESS ON THE QUESTIONNAIRE. INSTEAD, PLEASE USE THE NUMERIC USER ID THAT WE SEND TO YOU. We are using these numeric IDs to protect your privacy.

When you have completed the questionnaire, please mail it to:

**Chris Baum VanRyzin
forMemory
821 West Browning Street
Appleton, WI 54914**

Questions?

Please contact [Chris Baum VanRyzin](mailto:cbvanryzin@aol.com) at [904-734-9638](tel:904-734-9638) or cbvanryzin@aol.com.

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DATABASE QUESTIONNAIRE

II. YOUR SYMPTOMS

A. Please give us information on any symptoms you feel might be related to your memory loss.

Symptom	Do you have this symptom? Yes/No	Approximate Year Noticed	Is the symptom severe enough to interfere with daily life? Yes/No
Forgetting recently learned information			
Difficulty performing familiar tasks			
Problems finding words or talking			
Losing your train of thought while talking			
Getting lost			
Difficulty with driving			
Forgetting what day or time it is			
Poor or decreased judgment			
Problems with abstract thinking			
Problems recognizing people			
Losing things			
Changes in mood or behavior			
Feeling sad/anxious more often than before			
Loss of initiative			
Increased fatigue or exhaustion			
Migraines without aura			
Migraines with aura			
Visual aura without headache			
Problems with balance and coordination			
Tremors			
Muscle weakness			
Frequent body ache or pain			
Sensitivity to temperature extremes			
Inability to "see" things you're looking at			
Loss of sense of smell			
Auditory (hearing) hallucinations			
Hearing problems, even though hearing exam results are good			
Difficulty getting a good night's sleep			
Other:			
Other:			

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B. Were you forced to leave a job due to any of these symptoms? *(please check one)*

- Yes
 No

If No, please go to Section III.

C. How old were you when your symptoms first forced you to leave a job? _____

D. How long was it from when you first noticed symptoms to when you had to leave your job? *(check the best answer)*

- | | |
|--|---|
| <input type="checkbox"/> Less than a year | <input type="checkbox"/> About four years |
| <input type="checkbox"/> About a year | <input type="checkbox"/> About five years |
| <input type="checkbox"/> About two years | <input type="checkbox"/> More than five years |
| <input type="checkbox"/> About three years | |

III. YOUR DIAGNOSIS

Please think specifically about any diagnosis related to memory and thinking.

A. Have you discussed your memory loss with a doctor? *(please check one)*

- Yes
 No

If No, please skip to Section IV.

B. Year when you noticed first symptoms of memory loss: _____

C. Have you been given an MMSE (Mini Mental State Examination)? The MMSE is an 11 question test usually administered in your doctor's office. *(please check one)*

- Yes
 No
 Don't Know

If No or Don't Know, please skip to Question E in this section.

D. Please tell us what your MMSE score was for each year, if known. Maximum score is 30.

2004 _____ 2005 _____ 2006 _____ 2007 _____ 2008 _____

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E. Have you had any brain imaging done to look for the cause of your memory loss? *(please check one)*

- Yes
 No
 Don't Know

If No or Don't Know, please skip to Question G in this section.

F. Please specify the type of brain imaging you had done. *(please check all that apply)*

- MRI
 SPECT
 CT or CAT scan
 PET scan
 Don't Know
 Other: _____

G. Have you undergone neuropsychological testing? *(please check one)*

- Yes
 No
 Don't Know

If No or Don't Know, please skip to Question J in this section.

H. Have you had more than one neuropsychological test? *(please check one)*

- Yes
 No
 Don't Know

I. On average, how many hours did each neuropsychological test take? _____

J. Have you been tested for Alzheimer's-related genetic variations? *(please check one)*

- Yes
 No
 Don't Know

If No or Don't Know, please skip to Question L in this section.

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K. Please indicate results of any genetic testing in the table below. For each type of genetic variation, please put a check in the positive, negative or not tested column. Please check only one column for each variation.

Genetic Variation	Positive	Negative	Not Tested
APOE4			
PSN1			
PSN2			
APP			
Other:			
Other:			

L. Has your doctor given you a diagnosis for your memory loss? *(please check one)*

- Yes
 No

If No, please skip to Section IV.

M. Year diagnosed *(if diagnosed)* _____

N. What is your most recent diagnosis? *(please check the best answer)*

- Alzheimer's
 Probable Alzheimer's
 Dementia of the Alzheimer's type
 Vascular dementia
 Dementia with Lewy Bodies
 Frontotemporal dementia
 Cerebral amyloid angiopathy
 Mixed dementia
 Mild Cognitive Impairment
 Age-related memory loss
 Other: _____

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DATABASE QUESTIONNAIRE

IV. HOW ARE YOU DOING?

A. How are you doing compared to last year? For each item, please check one column (*on the following page*) to indicate whether you are better than last year, the same, worse, or you don't know.

	Better	Same	Worse	Don't Know
Short Term Memory				
Long Term Memory				
Balance & Coordination				
Energy Level				
Reading				
Cooking and Meal Preparation				
Housework				
Conversation				
Handling Finances				
Work (Paid or Volunteer)				
Driving				
Personal Care Functions (Dressing, Bathing, etc.)				

B. What is your perceived stress level this year?

- High
 Medium
 Low

V. MEDICAL AND FAMILY HISTORY

A. Have any of your immediate family members been diagnosed with memory loss, Alzheimer's or dementia? (*please check all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> Grandparent (paternal) | <input type="checkbox"/> Brother or Sister |
| <input type="checkbox"/> Grandparent (maternal) | <input type="checkbox"/> Child |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Uncle or Aunt |
| <input type="checkbox"/> Father | <input type="checkbox"/> Cousin |

B. How tall are you now? (*approximate height in inches*) _____

C. How much do you weigh now? (*approximate weight in pounds*) _____

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D. Last blood pressure reading, if know _____ / _____

E. Last cholesterol reading, if known LDL _____ HDL _____

F. Have you been taller in the past?

Yes

No

G. Besides memory loss, has a doctor told you that you have any of the following health conditions?

Condition	Yes/No	Year Diagnosed
Hypoglycemia or low blood sugar		
Diabetes		
High blood pressure or hypertension		
High cholesterol		
Seizure or seizure activity		
Stroke		
Transient ischemic attack		
Parkinson's disease		
Depression		
Anxiety		
Cardiovascular or heart disease		
Migraines		
Endocrine or thyroid problem		
Other:		
Other:		
Other:		

H. How many head injuries have you had? _____

How many times did you lose consciousness as a result of these injuries? _____

Approximate year of injury 1 _____

Approximate year of injury 2 _____

Approximate year of injury 3 _____

I. How many surgeries have you had where you were "put under" with anesthesia?

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DATABASE QUESTIONNAIRE

I. **For Women Only:** Hormone Supplementation and Birth Control
Men, please go to Question J in this Section.

I-1. Have you ever taken oral contraceptives? *(please check one)*

Yes No

If No, please go to Question 5 in this Section.

I-2. If you answered yes to question 1, for how many years did you take oral contraceptives? _____

I-3. Please list brands or formulations of oral contraceptives taken, if know.

I-4. Are you taking oral contraceptives now? *(please check one)*

Yes No

I-5. Have you reached menopause? For purposes of this questionnaire, menopause is defined as one year without a menstrual period. *(please check one)*

Yes No

If No, please go to Question 7 in this Section.

I-6. At what age did you reach menopause? _____

I-7. Have you ever taken hormone replacement therapy? *(please check one)*

Yes No

If No, please go to Question 10 in this Section.

I-8. For how many years did you take hormone therapy? _____

I-9. Please list brands or formulations of hormone replacement therapy taken, if known. _____

I-10. Are you currently taking hormone replacement therapy? *(please check one)*

Yes No

If No, please go to Question K.

I-11. If you are taking hormone replacement therapy now, do you believe it helps your memory and thinking?

Yes No Don't Know

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DATABASE QUESTIONNAIRE

J. **For Men Only:** Hormone Supplementation
Women, please go to Question K in this Section.

J-1. Have you ever used testosterone supplementation? *(please check one)*

Yes

No

If No, please go to Question K.

J-2. If you answered yes to question 1, for how many years did you take testosterone supplementation? _____

J-3. Please list brands or formulations of testosterone supplement taken, if known.

J-4. Are you currently using testosterone supplementation? *(please check one)*

Yes

No

J-5. If you are taking testosterone supplementation now, do you believe it helps your memory and thinking? *(please check one)*

Yes

No

Don't Know

K. Have you or your doctor observed that some substances seem to worsen your memory and thinking? *(please check all that apply)*

Sugar Substitutes

Monosodium Glutamate

Food Dyes

Chlorine

Peanuts

Shellfish/Iodine

Nitrates

Other: *(please write in name of substance)* _____

Other: *(please write in name of substance)* _____

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L. Think back over your childhood and adult life, work and home life. Were you ever exposed to hazardous waste, chemicals, pesticides, or potentially toxic substances? Please tell us the situation, the type of substance you were exposed to, and the approximate length of time you think you were exposed.

VI. LIFESTYLE

A. Have you used tobacco products such as cigarettes, pipe, cigar, chewing tobacco?

- Yes
 No

If No, please go to Question D in this Section.

B. Do you use tobacco products now?

- Yes
 No

C. Approximate number of years you used tobacco products. _____

D. On average, how often did you drink alcoholic beverages in the past?

- | | |
|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> 3 - 7 drinks per week |
| <input type="checkbox"/> Less than one drink per week | <input type="checkbox"/> More than 7 drinks per week |
| <input type="checkbox"/> 1 or 2 drinks per week | |

E. How often do you drink alcoholic beverages now?

- | | |
|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> 3 - 7 drinks per week |
| <input type="checkbox"/> Less than one drink per week | <input type="checkbox"/> More than 7 drinks per week |
| <input type="checkbox"/> 1 or 2 drinks per week | |

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DATABASE QUESTIONNAIRE

F. Which of the following have you tried to help your memory and thinking?
(Do not include vitamins, herbs, homeopathic remedies and supplements - these are discussed in Section IX. Check all that apply.)

- Exercise or physical therapy
- Meditation or deep breathing
- Aromatherapy
- Sacral-cranial massage therapy
- Other massage therapy
- Other: _____
- Other: _____

G. Of the lifestyle changes and therapies above, which do you believe helps your memory and thinking? (check all that apply)

- Exercise or physical therapy
- Meditation or deep breathing
- Aromatherapy
- Sacral-cranial massage therapy
- Other massage therapy
- Other: _____
- Other: _____

H. Have you tried to follow a particular diet? (check all that apply)

- Low carbohydrate
- Diabetic
- High protein
- Vegetarian
- Organic
- No dairy
- No gluten/wheat
- Other: _____
- Other: _____

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DATABASE QUESTIONNAIRE

I. Of the diets above, which do you feel help your memory and thinking?
(check all that apply)

- Low carbohydrate
- Diabetic
- High protein
- Vegetarian
- Organic
- No dairy
- No gluten/wheat
- Other: _____

J. How many hours per week do you engage in physical activity or exercise?
(include strenuous household chores and yard work) _____

K. During a typical day (24-hour period), how many hours do you spend sitting
(include working at a desk, eating, driving or riding, and watching TV). _____

L. How many hours per week do you spend meditating or doing deep breathing
exercises? _____

DATABASE QUESTIONNAIRE

VII. PRESCRIPTION MEDICINES

A. Please give us information on the prescription medications you take. Include all prescription medicines for all health problems, not just those for memory loss. If you take a prescription medicine that is not on this list, please write it down in the "Other" sections at the end of the list.

Name of Prescription Medicine	Have you ever taken this medicine? Yes/No	Dosage	Number of times taken per day	Approximate year you started taking this medicine	Approximate year you stopped taking this medicine <i>(if applicable)</i>
Actonel					
Amantadine					
Aricept					
Avandia					
Boniva					
Byetta					
Carbamezepine (Carbatrol)					
Celexa					
Chantix					
Effexor					
Eldepryl					
Evista					
Exelon					
Forteo					
Fosamax					
Glipizide					
Immitrex					
Lantus					
Levetiracetam (Keppra)					
Lexapro					
Lipitor					
Metformin					
Mevacor					
Namenda					
Naproxen (Prescription)					
Nexium					

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Name of Prescription Medicine	Have you ever taken this medicine? Yes/No	Dosage	Number of times taken per day	Approximate year you started taking this medicine	Approximate year you stopped taking this medicine <i>(if applicable)</i>
Opremazole					
Paxil					
Pentoxifylline					
Plavix					
Pramipexole (Mirapex)					
Provigil					
Prozac					
Razadyne					
Relpax					
Requip					
Risperdal					
Ritalin					
Selegiline					
Seroquel					
Synthroid					
Topamax					
Trileptal or Oxcarbazepine					
Verapomil					
Vytorin					
Xanax					
Zocor					
Zolof					
Zomig					
Zyprexa					
Other:					
Other:					
Other:					
Other:					
Other:					
Other:					

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B. Have you stopped taking any of these prescription medicines? Why?

VIII. OVER-THE-COUNTER MEDICINES

A. Please give us information on the over-the-counter (non-prescription) medicines you take. Include all over-the-counter medicines for all health problems. If you take an over-the-counter medicine that is not on the list, please write it down in the "Other" section at the end of the list.

Please do not include vitamins, herbs or supplements - these are covered in Section IX.

Name of Over-the-Counter Medicine	Do you take this medicine? Yes/No	Dosage	Number of times taken per day	Approximate year you started taking this medicine
Aspirin				
Ibuprofen (Advil)				
Naproxen (Aleve)				
Other:				
Other:				
Other:				

B. Have you stopped taking any of these over-the-counter medicines? Why?

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DATABASE QUESTIONNAIRE

IX. VITAMINS, SUPPLEMENTS AND HERBS

A. Please give us information on the vitamins, supplements and herbs you take. Include all vitamins, supplements and herbs for all health problems. If you take a vitamin, supplement or herb that is not on the list, please write it down in the "Other" section at the end of the list.

Name of Vitamin, Supplement or Herb	Do you take this medicine? Yes/No	Brand	Dosage	Number of times taken per day	Approximate year you started taking this medicine
Multivitamin					
Prenatal Multivitamin					
Vitamin B Complex					
Folates/Folic Acid					
Niacin B3					
B 12 Serum Shot					
Vitamin C					
Vitamin D					
Vitamin E					
Acetyl-L-carnitine					
Acetyl-L-cysteine					
Aeqorin					
Alpha lipoic acid					
Ashwangada root					
Calcium					
Calcium + D3					
Conjugated Linoleic Acid (CLA)					
CoQ10					
Cinnamon					
Cranberry Extract					
Damiana					
Evening Primrose Oil					
Feverfew					
Flax seed oil					
Ginger					
Ginkgo					
Gotu Kola					

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Name of Vitamin, Supplement or Herb	Do you take this medicine? Yes/No	Brand	Dosage	Number of times taken per day	Approximate year you started taking this medicine
Green tea extract					
Huperzine A					
Lecithin					
Linoleic acid from sunflower seed oil					
Melatonin					
Milk Thistle					
Omega 3/Fish Oil					
Passion Flower					
Phosphatidylserine (PS 100)					
Probiotics					
Red Clover					
Red Yeast Rice					
Resveratrol					
Rhodiola Rosea					
Schizandra					
Turmeric					
Vinpocetin					
White Willow					
Homeopathic remedy (please specify) _____					
Homeopathic remedy (please specify) _____					
Homeopathic remedy (please specify) _____					
Other:					
Other:					
Other:					
Other:					
Other:					

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