Last Name:_____ First:_____ M.I:____ Date of Birth:_____

Patient Medical Record Number:_____ SSN Last 4 Digest:_____

**PATIENT - PLEASE COMPLETE:**

## Thinking Ability Changes

1) I have noticed a recent decline in my memory. Yes☐ No☐

2) Others (my friends or family) tell me that I am forgetting things they tell me. Yes☐ No☐

3) My ability to concentrate seems to have declined recently. Yes☐ No☐

4) I have suffered recent losses that might hurt some of my thinking abilities. Yes☐ No☐

5) I get confused or easily distracted more than I used to. Yes☐ No☐

Family Observations:

**PROVIDER AND OFFICE STAFF USE ONLY**

Healthcare Provider Notes:

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**Staff Instructions:**

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