AD8 Questionnaire

This form should be filled out by someone **OTHER** than the patient, who is aware of the patient's ability to perform in the areas listed below. **If no one available, please complete yourself.**

Patient Name _____ **Date:** _____

Person filling out form _____ **Relationship** _____

Check "**YES a change**" if there has been a change in the last several years in items listed below **caused by thinking or memory problems**.	**YES A change**	**No**	**Don't Know**
1. Problems with judgment such as problems making decisions, bad financial decisions, and problems with thinking?			
2. Less interest in hobbies/activities?			
3. Repeats the same things over and over such as questions, stories, or statements?			
4. Trouble learning how to use a tool, appliance, or gadget such as the DVD player, computer, microwave, or remote control?			
5. Forgets correct month or year?			
6. Trouble handling complicated financial affairs such as balancing a checkbook, income taxes, and paying bills?			
7. Trouble remembering appointments?			
8. Daily problems with thinking and/or memory?			