MUSC Health
MEDICAL UNIVERSITY of SOUTH CAROLINA
South Carolina Alzheimer's Network (SCAN)
Department of Neurology
Medical University of South Carolina

SCAN Patient Symptom Questionnaire (PSQ)

The completion of this questionnaire is required before the initial SCAN consult. It may be completed by the referring provider or by the patient and their family/caregiver. If the latter, we recommend that a family member/caregiver help the patient fill out the form to ensure accuracy in the setting of possible cognitive impairment. Once completed, the questionnaire should be scanned into the patient's medical record to be reviewed by the SCAN team.

Patient's Name: _____

Who is completing this questionnaire? _____

1. BACKGROUND

a. How far did the patient go in school? _____

b. History of learning problems in school? ☐ YES ☐ NO

If yes, please explain.

_____

_____

c. Patient's occupation (please list past occupation if retired).

_____

d. Family history of memory problems or thinking? ☐ YES ☐ NO

If yes, please list the family member, symptoms/diagnosis and age diagnosed.

_____

_____

e. Does the patient have a previous diagnosis of dementia or cognitive impairment? ☐ YES ☐ NO

If yes, please list the diagnosis, date received, and name of person that provided the diagnosis:

_____

_____

2. HISTORY

a. When did the symptoms first appear?

_____

_____

b. What was the first symptom? For example: memory loss, difficulty finding words, change in personality, problems with walking, or something else.

_____

_____

c. Were the symptoms associated with anything when they began? For example: illness, hospitalization, surgery, new medication, change in life, stress.

_____

_____

d. What is the primary symptom/concern currently?

_____

_____

e. Did the patient's symptoms begin:

☐ Abruptly over days to weeks

☐ Gradually over months or years

f. Over time, have the patient's symptoms:

☐ Remained the same

☐ Fluctuated

☐ Improved

☐ Worsened

3. CURRENT SYMPTOMS

Does the patient have problems with (check all the boxes that apply):

Memory

- ☐ Repeating the same question or statement
- ☐ Misplacing items more than usual
- ☐ Forgetting the names of people you know well
- ☐ Forgetting recent events or conversations
- ☐ Forgetting dates or appointments

Visual Spatial Skills

- ☐ Following directions to a location
- ☐ Mistaking an object for something else
- ☐ Finding items when easily visible

Language

- ☐ Difficulty finding words
- ☐ Problems with writing
- ☐ Difficulty reading
- ☐ Saying the wrong word without realizing it
- ☐ Unable to understand what others say

Attention and Concentration

- ☐ Paying attention
- ☐ Staying focused
- ☐ Susceptibility to distraction

Driving

Has the patient had any recent:

- ☐ Accidents
- ☐ Near misses
- ☐ Episodes of getting lost
- ☐ Trouble parking, backing up, or making turns when driving
- ☐ Does not drive

Judgment and Problem Solving

Any difficulty with:

- ☐ Cooking
- ☐ Managing medications
- ☐ Shopping
- ☐ Planning or organizing activities
- ☐ Handling money
- ☐ Using appliances

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Does the patient have any of the following (check all boxes that apply):

Personality and Mood Changes

Loss of Interest

- ☐ In previous hobbies
- ☐ In social interactions

Changes in Temper or Personality

- ☐ Anger easily or more irritable
- ☐ More impatient
- ☐ Inappropriate social conduct
- ☐ New food cravings
- ☐ Compulsive behavior (for example: uncontrolled shopping or gambling)

Anxiety/Depressive Symptoms

- ☐ Increased anxiety/worry
- ☐ Excessive fatigue
- ☐ Panic attacks
- ☐ Sadness
- ☐ Tearfulness
- ☐ Feelings of hopelessness
- ☐ Loss of appetite
- ☐ Changes in sleep
- ☐ Thoughts of hurting oneself or suicide

Changes in Perception or Thinking

- ☐ Seeing or hearing things that are not there
- ☐ Mistaking objects for people or animals
- ☐ Paranoia or increased suspiciousness (for example: thinking someone stole something from the home)

Walking and Movement Changes

- ☐ Changes in walking (posture, unsteadiness, slowing)
- ☐ Slowing of movements
- ☐ Acting out dreams
- ☐ Falls
- ☐ Tremors
- ☐ Decreased facial expressions

Please list anything else we should know:

_____

_____

_____

4. BASIC ACTIVITIES OF DAILY LIVING: Does the patient require any assistance with the following?

Activity:	Needs no assistance or supervision= 0	Needs some assistance or supervision= 1	Totally dependent/cannot do at all= 2
Eating			
Toileting			
Bathing (sponge, shower, or tub)			
Dressing			
Grooming (combing, shampooing hair, trimming nails, shaving)			
Transferring (getting up from bed to chair)			

5. INSTRUMENTAL ACTIVITIES OF DAILY LIVING: Rate the patient's ability to perform the following complex tasks.

		Normal	Has difficulty but does by self	Requires some assistance	Completely dependent	Never did; would have difficulty now	Never did but could do now
1.	Writing checks, paying bills, balancing check book						
2.	Assembling tax records, business affairs, or papers						
3.	Shopping alone for clothes, household necessities, or groceries						
4.	Playing a game of skill, working on a hobby						
5.	Heating water, making a cup of coffee, turning off stove after use						
6.	Preparing a balanced meal						
7.	Keeping track of current events						
8.	Paying attention to, understanding discussing TV, book, magazine						
9.	Remembering appointments, family occasions, holidays, medications						
10.	Traveling out of neighborhood, driving, arranging to take buses						