

****This form is to be completed by someone who knows the patient well.**

****This form is NOT to be completed by the patient.**

Patient Name: _____ Date: _____

Name of person completing form: _____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems with making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR / DVD player, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			