**Cognitive Review of Systems**

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| Patient Name:  |  |  | Date:  |  |
| Person filling out form:  |  |  |  |
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| --- | --- | --- |
| 1. Cognitive
	1. Memory
		1. Forgets appointments…………………………………………………………
		2. Loses things (keys, wallet, purse)………………………………………..
		3. Repeats words or questions……………………………………………….
		4. Forgets names of close friends or family…………………………….
 | YesYesYesYes | NoNoNoNo |
| * 1. Attention
		1. Has trouble following a TV program……………………………………
		2. Has trouble staying on topic when talking………………………….
		3. Has trouble finishing tasks after starting…………………………….
 | YesYesYes | NoNoNo |
| * 1. Visuo-spatial
		1. Has trouble finding objects in the room………………………………
		2. Complains about changes in vision……………………………………..
		3. Sees things that aren’t real…………………………………………………
 | YesYesYes | NoNoNo |
| * 1. Verbal Skills
		1. Has trouble naming things correctly……………………………………
		2. Has trouble talking in full sentences……………………………………
		3. Has trouble repeating single words…………………………………….
 | YesYesYes | NoNoNo |
| * 1. Orientation
		1. Does not know the time or date…………………………………………
		2. Does not know where he/she is (place, city, state)……………..
 | YesYes | NoNo |

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| 1. Behavioral
	1. Personal
		1. Has trouble cooking or following recipes…………………………….
		2. Has trouble using the TV remote or cell phone…………………..
		3. Has trouble bathing…………………………………………………………….
		4. Has trouble getting dressed………………………………………………..
		5. Has recent weight gain or weight loss…………………………………
 | YesYesYesYesYes | NoNoNoNoNo |
| * 1. Financial
		1. Has trouble managing money……………………………………………..
		2. Has trouble paying bills……………………………………………………….
 | YesYes | NoNo |
| * 1. Gait Stability
		1. Has a shuffling gait (takes very short steps)………………………..
		2. Has trouble with dizziness…………………………………………………..
		3. Has trouble with falls………………………………………………………….
		4. Has numbness in legs………………………………………………………….
 | YesYesYesYes | NoNoNoNo |
| * 1. Bladder and Bowels
		1. Has urinary incontinence (can’t make it to bathroom)………..
		2. Has bowel movement accidents…………………………………………
 | YesYes | NoNo |
| * 1. Driving Ability
		1. Gets lost while driving…………………………………………………………
		2. Family is worried about patient’s driving…………………………….
 | YesYes | NoNo |
| 1. Emotional
	* 1. Has lost interest in things……………………………………………………
		2. Has depression (sadness) or anxiety……………………………………
		3. Has problems with yelling, hitting, or pacing………………………
		4. Has changes in personality………………………………………………….
		5. Is confused while hospitalized…………………………………………….
		6. Patient believes they have a memory problem………….……….
 | YesYesYesYesYesYes | NoNoNoNoNoNo |

Any additional confidential Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_