**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……………………………. | Yes  Yes  Yes  Yes | No  No  No  No |
| * 1. Attention      1. Has trouble following a TV program……………………………………      2. Has trouble staying on topic when talking………………………….      3. Has trouble finishing tasks after starting……………………………. | Yes  Yes  Yes | No  No  No |
| * 1. Visuo-spatial      1. Has trouble finding objects in the room………………………………      2. Complains about changes in vision……………………………………..      3. Sees things that aren’t real………………………………………………… | Yes  Yes  Yes | No  No  No |
| * 1. Verbal Skills      1. Has trouble naming things correctly……………………………………      2. Has trouble talking in full sentences……………………………………      3. Has trouble repeating single words……………………………………. | Yes  Yes  Yes | No  No  No |
| * 1. Orientation      1. Does not know the time or date…………………………………………      2. Does not know where he/she is (place, city, state)…………….. | Yes  Yes | No  No |

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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………………………………… | Yes  Yes  Yes  Yes  Yes | No  No  No  No  No |
| * 1. Financial      1. Has trouble managing money……………………………………………..      2. Has trouble paying bills………………………………………………………. | Yes  Yes | No  No |
| * 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…………………………………………………………. | Yes  Yes  Yes  Yes | No  No  No  No |
| * 1. Bladder and Bowels      1. Has urinary incontinence (can’t make it to bathroom)………..      2. Has bowel movement accidents………………………………………… | Yes  Yes | No  No |
| * 1. Driving Ability      1. Gets lost while driving…………………………………………………………      2. Family is worried about patient’s driving……………………………. | Yes  Yes | No  No |
| 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………….………. | Yes  Yes  Yes  Yes  Yes  Yes | No  No  No  No  No  No |

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