



# Potential Research Subject Intake Form

350 Parnassus Ave, Suite 905  
San Francisco, California 94117  
tel: 415.476.6880  
fax: 415.476.2921  
memory.ucsf.edu

**Mailing Address:**  
UCSF Box 1207  
San Francisco, CA 94143-1207

Though this form is not necessary to participate in our research studies, completing it to the best of your ability will expedite the review process.

## Main Contact Information

Please appoint a single contact person who will be responsible for communicating with our research team.

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Home  Office  Mobile

Alternate phone number: \_\_\_\_\_

Home  Office  Mobile

Fax number: \_\_\_\_\_

I am:

The patient seeking evaluation

A family member of the patient

A friend of the patient

Other (please specify): \_\_\_\_\_

I am the:

Durable Power of Attorney

Health Care Proxy

Neither

Other (please specify): \_\_\_\_\_

**Patient Information (if different from that listed above)**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Date of birth: (m/d/yy) \_\_\_\_\_

Gender:  Male  Female

Mailing address: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Home  Office  Mobile

Alternate phone number: \_\_\_\_\_

Home  Office  Mobile

Fax number: \_\_\_\_\_

**Doctor Information**

Primary Care Doctor

Name: \_\_\_\_\_

Medical group/hospital affiliation: \_\_\_\_\_

Office mailing address: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Home  Office  Mobile

Alternate phone number: \_\_\_\_\_

Home  Office  Mobile

Fax number: \_\_\_\_\_

Check here if we have your permission to contact this doctor to coordinate care.

Neurologist

Name: \_\_\_\_\_

Medical group/hospital affiliation: \_\_\_\_\_

Office mailing address: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Home  Office  Mobile

Alternate phone number: \_\_\_\_\_

Home  Office  Mobile

Fax number: \_\_\_\_\_

Check here if we have your permission to contact this doctor to coordinate care.

Other Physician

Name: \_\_\_\_\_

Medical group/hospital affiliation: \_\_\_\_\_

Office mailing address: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Home  Office  Mobile

Alternate phone number: \_\_\_\_\_

Home  Office  Mobile

Fax number: \_\_\_\_\_

Check here if we have your permission to contact this doctor to coordinate care.

**The following questions should be completed for the patient.**

1. Are you right or left handed?

Right handed

Left handed

Ambidextrous

2. How many years of regular school you have completed? \_\_\_\_

0 = No formal school

12 = Completed High School/GED

14 = 2 years college

16 = 4 years college

17-18 = 1 or more years of post graduate (Master's)

19-22 = Graduate or professional degree (PhD, MD, JD)

99 = Decline to state

3. What is your marital status?

Currently married or living with partner

Separated

Divorced

Widowed

Never married

Decline to state

4. Are you a veteran?  Yes  No

5. Have you been evaluated at UCSF before?  Yes  No

5.a. If yes, please specify:

I am a UCSF clinical patient

I have participated in research studies at UCSF

6. Do you have any allergies?  Yes  No  
6.a. If yes, please list: \_\_\_\_\_
7. First noticeable symptom  
7.a. Describe the first symptom: \_\_\_\_\_  
7.b. Date of the first symptom: \_\_\_\_\_
8. Do you have a family history of neurological disease?  Yes  No  
8.a. If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
9. Have you ever traveled outside the US?  Yes  No  
9.a. If so, where and for how long?: \_\_\_\_\_  
\_\_\_\_\_
10. List all medical conditions you have or have had: \_\_\_\_\_  
\_\_\_\_\_
11. List current medications (including over-the-counter medications, supplements, herbals) : \_\_\_\_\_  
\_\_\_\_\_
12. Have you had a brain MRI performed?  Yes  No  
12.a. If so, when? \_\_\_\_\_  
12.b. Where was this MRI performed? \_\_\_\_\_
13. Have you ever had a lumbar puncture (spinal tap)?  Yes  No  
13.a. If so, when? \_\_\_\_\_  
13.b. Where and in what facility was this done? \_\_\_\_\_

I understand that I must send the research team a copy of my medical records in order to be considered for research.

I understand that cases are prioritized based on the urgency of the medical condition as assessed by review of the medical records.

Thank you for completing this form. Please print a copy and mail or fax it to:

Dr. Michael Geschwind  
University of California, San Francisco  
Memory and Aging Center  
350 Parnassus Ave, Suite 905 / Box 1207  
San Francisco, CA 94143-1207

Fax: (415) 476-2921