ReCODE - AQ21

Patient's Name_______________________________

Your Name __________________________

Date of Birth _________________________

Date________________________________

1. Does your loved one have memory loss?*

Yes No

2. If you answered yes to question 1, is their memory worse than it was a few years ago?

Yes No

3. Do they repeat statements or stories in the same day?*

Yes No

4. Have you had to take over tracking events or appointments, or does the patient forget appointments?

Yes No

5. Do they misplace items more than once a month?

Yes No

6. Do they suspect others of hiding or stealing items when they cannot find them?

Yes No

7. Does your loved one frequently have trouble knowing the day, date, month, year, and time; or check the date more than once a day?*

Yes No

8. Do they become disoriented in unfamiliar places?

Yes No

9. Do they become more confused when not at home or while traveling?

Yes No

10. Excluding physical limitations, do they have trouble handling money, such as tips or calculating change?

Yes No

11. Do they have trouble paying bills or doing finances?*

Yes No

12. Do they have trouble remembering to take medicines or keeping track of medications taken?

Yes No

13. Does your loved one have difficulty driving; or are you concerned about their driving?

Yes No

14. Are they having trouble using appliances such as the stove, phone, remote control, or microwave?

Yes No

15. Excluding physical limitations, are they having difficulty completing home repair or housekeeping tasks?

Yes No

16. Excluding physical limitations, have they given up or cut down on hobbies or crafts?

Yes No

17. Are they getting lost in familiar surroundings, such as their own neighborhood?*

Yes No

18. Is their sense of direction failing?

Yes No

19. Do they have trouble finding words other than names?

Yes No

20. Do they confuse names of family members or friends?*

Yes No

21. Do they have trouble recognizing familiar people?*

Yes No

Total points = _____________