



Research Volunteer Form

Today's Date: _____ Caller's name: _____

How did you hear about the MADC?

- Own doctor
- MADC website
- MADC newsletter
- Alzheimer's Association
- Other _____
- Radio Announcement
- TV
- Event (research talk or Walk to End Alzheimer's)
- Health Fair

Name of interested volunteer: _____

Address: _____

City: _____ State _____ Zip: _____ County: _____

Phone: _____ Email: _____

Gender: _____ Date of Birth: _____ Age: _____ Years of education: _____

Race/Ethnicity

- Black/African-American
- White/Caucasian
- Asian American/Pacific Islander
- Hispanic
- American Indian/Native Alaskan
- Other (please specify) _____

Are you interested in serving as a healthy volunteer for a study? ___Yes ___No

Are your memory, thinking skills, or ability to reason worse than a year ago? ___Yes ___No

If yes, when and what type of changes did you (or someone else) notice? (e.g. mood, memory or thinking changes) _____

Have you seen a specialist (e.g. neurologist / geriatrician)? ___Yes ___No

Have you received a diagnosis for your memory/thinking changes? ___Yes ___No

If yes, diagnosis _____ Date: _____

Do you, or have you ever received medical care at U of M? ___Yes ___No

If yes, can we look at your medical information to help us find the best study for you?
___ Yes ___ No MRN#: _____

Are you a Veteran of the U. S. Armed Forces? ___Yes ___No

If yes, discharge status: _____

Do you receive medical care at the VA? ___Yes ___No

If yes, which location? _____

Are you currently a licensed driver? ___ Yes ___ No

Do you drive regularly? ___ Yes ___ No



Do you have someone who could serve as a study partner or informant for a study?

(generally a spouse, family member or close friend) ___ Yes ___ No (who?) _____

Relationship to informant: _____

Study partner contact info: _____

When are you available to start a study? _____

Are there times when you are unavailable? i.e. Do you travel for long periods of time? ___ Yes ___ No

If yes, please specify. _____

Which types of studies are you interested in learning more about?

- Caregiver
- Depression & mood change
- Detection & diagnosis
- Driving safety
- Education & support
- Family & couple relationships
- Genetics & genetics testing
- Potential new medications
- Potential new non-medication trials

Medical History

Do you have, or have you had in the past, any difficulty with the following?

1. Seizures? ___ Yes ___ No (if yes when?) _____

2. Stroke? ___ Yes ___ No (if yes when?) _____

3. Head Injury? ___ Yes ___ No (if yes when?) _____

Did it involve loss of consciousness? ___ Yes ___ No (if yes, for how long?) _____

Were you hospitalized? ___ Yes ___ No (if yes, for how long?) _____

Was the concussion sports-related? ___ Yes ___ No

(if yes, years playing contact sports, number of concussions, highest level played)

4. Cancer? ___ Yes ___ No (if yes when/type?) _____

If yes, type of treatment e.g. chemo/radiation, dose if known _____

5. Pacemaker/defibrillator or other implanted devices? ___ Yes ___ No (if yes when/type?) _____

6. Hearing problems? ___ Yes ___ No (if yes, are they corrected?) _____

7. Vision problems? ___ Yes ___ No (if yes, are they corrected?) _____

8. Depression? ___ Yes ___ No (if yes when?) _____

9. Anxiety? ___ Yes ___ No (if yes when?) _____

10. Have you ever received treatment for alcohol or substance abuse? ___ Yes ___ No

If yes, please specify. _____

11. Learning disorders or difficulties in school? ___ Yes ___ No

12. Difficulty understanding language either spoken or written? ___ Yes ___ No

13. What language do you speak every day? _____

Is this your first language? ___ Yes ___ No



Are there other languages you speak fluently? ___ Yes ___ No

How long have you spoken this language? _____

14. Are you seeing a physician for any other chronic medical illnesses? ___ Yes ___ No

(if yes, what?) _____

15. Are you currently taking medication or treatment for any of these problems?

Memory loss or dementia? ___ Yes ___ No (if yes, what?) _____

Depression? ___ Yes ___ No (if yes, what?) _____

Anxiety? ___ Yes ___ No (if yes, what?) _____

Blood thinner like Warfarin or Coumadin? ___ Yes ___ No (if yes, what?) _____

Diabetes ___ Yes ___ No (if yes, what?) _____

Hypertension? ___ Yes ___ No (if yes, what?) _____

High cholesterol? ___ Yes ___ No (if yes, what?) _____

16. Do you have trouble falling asleep? ___ Yes ___ No

17. Do you have trouble staying asleep once you fall asleep? ___ Yes ___ No

18. Have you ever been told you stop breathing while asleep? ___ Yes ___ No

19. How much sleep do you get per night on average? ___ hours

20. Have you ever been told you act out dreams and thrash arms/legs? ___ Yes ___ No

21. Have you ever been diagnosed with a sleep disorder? (obstructive sleep apnea, REM sleep disorder)

___ Yes ___ No (if yes, what/when?) _____

22. Handedness: ___ Right ___ Left ___ Use of both hands equally

23. Do you have any relatives who have been given a diagnosis of a dementia causing condition such as Alzheimer's disease, frontotemporal dementia, Lewy body dementia, Parkinson's disease?

___ Yes ___ No (please specify)

Parent(s) _____

Sibling(s) _____

Grandparent(s) _____

Other _____

24. Please indicate whether you would consider participating in studies including the following research activities.

Mail-in questionnaires

Telephone questionnaires

Face-to-face interviews

Psychological or memory testing

Physical exam

Providing a blood sample (including genetic testing)

Studies involving imaging scans (MRI, PET, x-ray, CT)

EEG (electroencephalogram) (recording of brain wave patterns)

Medical studies which involve collection of CSF (cerebrospinal fluid) via lumbar puncture

Medical studies involving medications



MICHIGAN ALZHEIMER'S DISEASE CENTER

UNIVERSITY OF MICHIGAN

Please use the following space to include or explain any other conditions or circumstances you think may be relevant to your participation in a research study/project.

Thank you for taking the time to fill out this form. We will review your information and contact you to discuss studies that best meet your needs and interests. If you have any questions, please feel free to contact the MADC at (734) 763-2361 or visit our web site at www.alzheimers.med.umich.edu
The Michigan Alzheimer's Disease Core Center is funded by the National Institute on Aging (P30AG053760).

Please mail completed form to:

**Michigan Alzheimer's Disease Center
2101 Commonwealth Blvd., Suite D
Ann Arbor, MI 48105**

To be completed by MADC staff only:

MADC staff name: _____

Date: _____

MADCRVFID _____

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