



## Research Volunteer Form

Today's Date: \_\_\_\_\_ Caller's name: \_\_\_\_\_

### How did you hear about the MADC?

- |  |   |
|--|---|
| <input type="checkbox"/> Own doctor              | <input type="checkbox"/> Radio Announcement                               |
| <input type="checkbox"/> MADC website            | <input type="checkbox"/> TV   |
| <input type="checkbox"/> MADC newsletter         | <input type="checkbox"/> Event (research talk or Walk to End Alzheimer's) |
| <input type="checkbox"/> Alzheimer's Association | <input type="checkbox"/> Health Fair                                      |
| <input type="checkbox"/> Other _____             |   |

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?

- |   |  |
|---|--|
| <input type="checkbox"/> Caregiver                | <input type="checkbox"/> Family & couple relationships       |
| <input type="checkbox"/> Depression & mood change | <input type="checkbox"/> Genetics & genetics testing         |
| <input type="checkbox"/> Detection & diagnosis    | <input type="checkbox"/> Potential new medications           |
| <input type="checkbox"/> Driving safety           | <input type="checkbox"/> Potential new non-medication trials |
| <input type="checkbox"/> Education & support      |  |

### **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



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.

Lined area for providing additional information or conditions.

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 \_\_\_\_\_