MICHIGAN ALZHEIMER'S DISEASE CENTER
UNIVERSITY OF MICHIGAN

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: ________________

Occupation/Last Occupation prior to Retirement: ____

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) Did the changes happen suddenly or slowly over time? __________________
____

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, years of service, highest rank: ____________________________________
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 any times that you are unavailable (ex: regular travel)? ________________________________

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 ***OR*** Epilepsy? ___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/these language(s)?_____

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.

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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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