Study ID: HUM00000382 IRB: IRBMED Date Approved: 8/19/2020 Expiration Date: 8/18/2021

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

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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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