Preclinical Mobile Alzheimer Check-Up

1 **Why would you like this assessment?**

☐ General brain health ☐ Family history ☐ Memory concerns

2 **Have you noticed changes in your memory, word-finding, or ability to find your way?**

☐ Yes ☐ No ☐ Not sure

If yes, briefly describe when they started and whether they are getting worse.

3 **Do these changes make everyday tasks more difficult?**

For example, managing medication, appointments, or money.

☐ Yes ☐ No ☐ Not applicable

4 **Has anyone in your family had Alzheimer's disease, another type of dementia, or Parkinson's disease?**

☐ Yes ☐ No ☐ Not sure

If yes, give their relationship to you and approximate age when symptoms started. Please do not give names.

5 **Do you have any ongoing health conditions or a history of serious head injury?**

Please mention any memory-related diagnosis, Parkinson's disease, stroke, kidney disease, diabetes, or high blood pressure.

Answer: .....

6 **Which medicines or supplements do you take regularly?**

Please list their names: .....

7 **Have you had a memory assessment, brain scan, or Alzheimer's blood/genetic test before?**

☐ Yes ☐ No ☐ Not sure

If yes, which test and approximately when?

Thank you. Your answers will help our specialist review your health history.

This questionnaire is not a diagnostic test or a genetic testing consent form.