Dementia Caregiver Medical Update Form

Use this form to track important changes and share helpful updates before a medical visit.

PATIENT INFO

PATIENT NAME _____
DATE OF BIRTH _____
DOCTOR NAME _____

CAREGIVER NAME _____
RELATIONSHIP _____
APPOINTMENT DATE _____

OVERALL CHANGES SINCE LAST VISIT

Check all that apply)

□ No major changes
□ Gradual decline
□ Sudden change
□ New behaviors
□ Increased confusion
□ Increased physical needs

BRIEF SUMMARY IN YOUR OWN WORDS:

_____
_____
_____
_____
_____
_____

MEMORY & THINKING CHANGES

Increased forgetfulness? □ Yes □ No
Repeating questions more often? □ Yes □ No
Confusion about time/place? □ Yes □ No
Trouble recognizing people? □ Yes □ No

EXAMPLES OR CONCERNS:

_____
_____
_____
_____

BEHAVIOR & MOOD CHANGES

(Check any that apply)

□ Agitation / irritability
□ Anxiety
□ Depression / sadness
□ Crying episodes
□ Anger or aggression
□ Hallucinations (seeing/hearing things)
□ Paranoia / suspicion
□ Wandering
□ Shadowing (following caregiver)

WHAT TRIGGERS IT / WHEN DOES IT HAPPEN?

_____
_____
_____
_____

SLEEP PATTERNS

- Sleeping well at night? □ Yes □ No
- Waking frequently? □ Yes □ No
- Sleeping more during the day? □ Yes □ No
- Nighttime wandering? □ Yes □ No

NOTES:

_____
_____
_____
_____

Bring this form to appointments or send updates ahead of time so important changes are not missed.

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EATING & DRINKING

Appetite: □ Good □ Fair □ Poor
Weight change? □ Loss □ Gain □ No change
Trouble chewing/swallowing? □ Yes □ No
Needs help eating? □ Yes □ No

FLUIDS INTAKE CONCERNS:

TOILETING & BOWEL/BLADDER CHANGES

Incontinence: □ None □ Occasional □ Frequent
Constipation? □ Yes □ No
Diarrhea? □ Yes □ No
Urinary changes (burning, frequency, odor)? □ Yes □ No

NOTES:

MOBILITY & PHYSICAL CHANGES

Walking ability: □ Independent □ Needs help □ Unable
Falls? □ Yes □ No (How many: __)
Balance issues? □ Yes □ No
Weakness? □ Yes □ No

PAIN CONCERNS:

MEDICATIONS

Any new medications? □ Yes □ No
Any stopped medications? □ Yes □ No
Any side effects noticed? □ Yes □ No

CONCERNS OR QUESTIONS:

CARE NEEDS & SAFETY

Can be left alone? □ Yes □ No
Needs supervision? □ Yes □ No
Safety concerns (wandering, stove, driving, etc.):

MORE DETAILS OR SAFETY CONCERNS:

URGENT CONCERNS FOR DOCTOR

(Top 3 things you want addressed)

1. _____
2. _____
3. _____

QUESTIONS FOR THE DOCTOR

TIMELINE OF CHANGES

When did you first notice changes?

_____

Have symptoms gotten worse quickly or slowly?

_____

_____

HOW IS CAREGIVING GOING RIGHT NOW?

Bring this form to appointments or send updates ahead of time so important changes are not missed.

Need more caregiver support?
Visit AlzheimersInYourHome.com for dementia care tips, caregiver tools, and helpful resources.