Élan Alzheimer disease patient questionnaire

Thank you for contacting us about your potential participation in a research study of an investigational drug for Alzheimer's disease. If you qualify for participation, all study-related physical exams, tests, evaluations, procedures, and study medication will be provided to you at no cost.
If you are interested, you may want to complete this questionnaire, and send it back to us. It is voluntary.
All personal and medical information obtained will be kept confidential. You don't have to answer questions that you do not want to, and you can stop this interview at anytime. If you choose, and are eligible to participate in this study, this survey will be kept with your other research records. If you provide this questionnaire and are not eligible, this questionnaire will be destroyed. These records are accessible to the research staff and will not be shared with anyone else without your written permission.

Are you interested in participating in this study? ☐ Yes ☐ No

Do we have your permission to obtain the personal medical information per the questionnaire ? ☐ Yes ☐ No

Upon completion, please return this form to Bay Area Research Institute
Fax: (925) 283-9007
Email info@BayAreaResearch.com
Mail address: 3736 Mt. Diablo Blvd., Suite 204, Lafayette, CA 94549

Date ______________________

Patient's Name ____

Caregiver's Name ____

Gender: ____________________ Age/Date of Birth ________________________

Phone (Day) ________________ Phone (PM) ____________________________

Cell Phone __________________ Email __________________________________

Address ____

____

1. How did you hear about this study?
____

2. Have you been diagnosed with Alzheimer disease?

Yes ☐ When? _____________ No ☐

3. Have you had a head scan?

Yes ☐ When? _____________ No ☐

4. Do you have any major problems with vision or hearing that would make it difficult to complete testing in the study?
No ☐ Yes ☐ Specify ____

5. If female: have you completed menopause or have had surgical sterilization?
Yes ☐ Specify _________________When? ___________ No ☐

6. Are you fluent in English?
Yes ☐ No ☐

7. Did you complete at least 6 years of school?
Yes ☐ No ☐

8. Is there a caregiver that sees the patient at least 5 times a week and can come for all study visits to answer questions?
Yes ☐ No ☐

9. What is your body weight? ________ height? _________

10. Are you currently using any medication to treat Alzheimer's disease?
No ☐ Yes ☐Specify names and start dates:
____
____
____
Has the dose of Alzheimer medication has changed within last 120 days?
No ☐ Yes ☐
Do you anticipate any dose changes in the future?
No ☐ Yes ☐
Do you have any significant side effects from your Alzheimer's disease medication?
No ☐ Yes ☐
Specify____

11. What other medications or dietary supplements do you take on the regular or occasional basis?
____
____
____
____
____

12. Have you started any of these medications within the last 30 days?
No ☐ Yes ☐ Specify
____
____

13. Have you recently discontinued any medication?
No ☐ Yes ☐ Specify____
____

14. Do you have any significant medical problems or allergies, including drug allergies?
No ☐ Yes ☐ Specify____
Particularly, do you have history of any of the following?

High blood pressure	☐ No	☐ Yes
Heart attack	☐ No	☐ Yes
Other heart/blood vessels disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Seizure disorder	☐ No	☐ Yes
Other brain injury or disease	☐ No	☐ Yes
Carotid or vertebrobasilar stenosis	☐ No	☐ Yes
Lung disease	☐ No	☐ Yes
Abdomen problems	☐ No	☐ Yes
Liver disease	☐ No	☐ Yes
Kidney disease	☐ No	☐ Yes
Blood disease	☐ No	☐ Yes
Hormonal problems	☐ No	☐ Yes
Crohn’s disease	☐ No	☐ Yes
Rheumatoid arthritis	☐ No	☐ Yes
Other autoimmune disease	☐ No	☐ Yes
Cancer within last 5 years	☐ No	☐ Yes
Allergy	☐ No	☐ Yes
Severe hearing impairment	☐ No	☐ Yes
Severe vision impairment	☐ No	☐ Yes
Serious infection within last 30 days	☐ No	☐ Yes

15. Do you have history of other psychiatric disorders?
No ☐ Yes ☐ Specify____
If Yes, do you have any symptoms now?
No ☐ Yes ☐ Specify____

16. Do you smoke?
☐No ☐ Yes How many per day? ________

17. How much alcohol do you drink on the weekly basis? ______________
☐No ☐ Yes

18. Have you donated blood in the last three months?
☐No ☐ Yes Specify ____

19. Have you participated in any clinical trial or taken any investigational drug in the last 60 days?
☐No ☐ Yes Specify ____

20. Have you ever received any prior experimental treatment with Epineuzumab, AN1792, ACC-001, or other experimental immunotherapeutic or vaccine for AD?
☐No ☐ Yes Specify ____

21. Have you received any biologic product or immunologic medication for any reason other than Alzheimer disease within last 3 years?
☐No ☐ Yes Specify ____

22. Study will involve testing for a genetic factor that plays a role in Alzheimer disease. Are you OK with this?
☐Yes ☐No

23. Study will involve intravenous medication, six infusions. Are you OK with this?
☐Yes ☐No

24. Study will involve MRI testing, which is a painless imaging of the brain, seven times over 18 months. Are you OK with this?
☐Yes ☐No

25. There are certain conditions when the MRI cannot be taken. Do you have any of the following: presence of pacemakers, aneurysm clips, artificial heart valves, ear implants, cerebrospinal fluid shunts, metal foreign objects in the eyes, skin, or body, red color tattoo, or claustrophobia.
Does any of these apply to you?
☐No ☐ Yes

26. Do lab technicians have major difficulties finding a vein when the blood is drawn?
☐No ☐ Yes

Would you like to be contacted by the site staff? ☐ Yes ☐ No

Do we have your permission to retain this information for our files? ☐ Yes ☐ No
If No, do NOT send it to us.

Thank you.

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