Brain Tissue Donation Questionnaire

› *This form must be completed by the family and sent to the Brain Bank ahead of time.*

Please mail, email, or fax this form to:

Rachel LaPaille-Harwood
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Birdsall Building, Room 310
Jacksonville, FL 32224
Email: lapaille-harwood.rachel@mayo.edu
Phone: 904-953-2439
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Date of completion: _____

Name of patient: _____

Address: _____

City: _____ **State/Province:** _____ **ZIP code:** _____ **Country:** _____

Phone: _____ **Email:** _____

Name of next of kin: _____

Relationship to patient: _____

Address of next of kin: _____

City: _____ **State/Province:** _____ **ZIP code:** _____ **Country:** _____

Phone: _____ **Email:** _____

Patient's date of birth: _____

Sex assigned at birth: ☐ Female ☐ Male Preferred gender pronoun(s) to use: _____

Race: ☐ Asian ☐ Black or African American ☐ Hawaiian or Other Pacific Islander
☐ Native American, Indigenous, or Alaska Native ☐ White ☐ Other

Ethnicity: ☐ Of Hispanic, Latino, or Spanish Origin ☐ Not of Hispanic, Latino, or Spanish Origin

Current neurological diagnosis:

☐ Progressive supranuclear palsy (PSP)

☐ Corticobasal degeneration/syndrome (CBD/CBS)

☐ Multiple system atrophy (MSA)

☐ Frontotemporal dementia with parkinsonism (FTDP)

☐ Other: _____

Year of diagnosis: _____

Year of symptoms onset: _____

What were the patient's early symptoms, in the first year before/of diagnosis?

_____

_____

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What symptoms has the patient experienced since the initial onset *(check all that apply)*:

Movement symptoms:

- ☐ Tremors
- ☐ Imbalance/frequent falls
- ☐ Difficulty with walking
- ☐ Difficulty with general coordination
- ☐ Difficulty moving/using hands
- ☐ Stiffness/rigidity of muscles
- ☐ Painful muscle contractions ("dystonia")

Other: _____

_____

_____

_____

Cognitive changes:

- ☐ Short-term memory loss
- ☐ Long-term memory loss
- ☐ Loss of orientation (e.g., not knowing the year, familiar locations, familiar people)
- ☐ Difficulty with word finding
- ☐ Poor judgment
- ☐ Disinhibited behavior
- ☐ Impulsivity
- ☐ Delusions (e.g., paranoia)
- ☐ Hallucinations
- ☐ Uncontrolled laughing or crying
- ☐ Personality changes

Other: _____

_____

_____

_____

Autonomic symptoms:

- ☐ Dizziness
- ☐ Difficulty with blood pressure regulation/fainting
- ☐ Excessive sweating
- ☐ Changes to breathing (e.g., shortness of breath, labored breathing, sudden large breaths)
- ☐ Changes to bladder or bowel function
- ☐ Sexual dysfunction
- ☐ Changes to circulation (e.g., discoloration in hands or feet)

Other: _____

_____

_____

_____

Vision changes:

- ☐ Double vision
- ☐ Blurry vision
- ☐ Dry eyes
- ☐ Difficulty moving eyes
- ☐ Difficulty opening and/or closing eyelids

Other: _____

_____

_____

_____

Sleep changes:

- ☐ Development of sleep apnea
- ☐ Acting out dreams
- ☐ Restless leg syndrome
- ☐ Difficulty falling or staying asleep at night
- ☐ Daytime fatigue/sleepiness

Other: _____

_____

_____

_____

Other symptoms:

- ☐ Changes to speech/voice
- ☐ Difficulty with swallowing
- ☐ Weight loss
- ☐ Anxiety
- ☐ Depression
- ☐ Apathy

Other: _____

_____

_____

_____

Does the patient have a known history of:

Alcoholism: ☐ Yes ☐ No

Drug use: ☐ Yes ☐ No

High blood pressure: ☐ Yes ☐ No

Other known medical conditions or primary symptoms: _____

_____

_____

Is the patient ☐ left- or ☐ right-handed?

Which side of the body have the movement symptoms mainly affected? _____

What medications has the patient taken to manage the symptoms since the neurological diagnosis?

_____

_____

_____

_____

What kind of professional work did/does the patient do? _____

Does the patient have a history of brain injury or possible brain injury? ☐ Yes ☐ No

For example, a history of trauma or repeated concussions related to combat, work activities, or sports.

Please provide details here: _____

_____

Is there a family history of movement or memory disorders or other neurological diseases? ☐ Yes ☐ No

Please list diagnoses and the relationship of the person to the patient *(e.g., Alzheimer's disease – father)*

_____

_____

Most recent physician who managed the patient's neurological diagnosis and care:

Name of physician: _____

Specialty *(neurology, primary care, etc.)*: _____

Facility/Hospital: _____

Facility address: _____

City: _____ State/Province: _____ ZIP code: _____

Phone: _____ Fax: _____

Email *(if available)*: _____

If patient is under care of hospice:

Name of hospice agency: _____

Facility address *(if person is residing in inpatient hospice)*: _____

_____

Contact person: _____

Phone: _____ Email: _____

If patient resides in a skilled nursing or assisted living facility:

Name of facility: _____

Facility address: _____

Contact person: _____

Phone: _____ Email: _____