Cholesterol Drugs and Memory Questionnaire

---These data will be used for research purposes only. Your personal information will not be released.---

Part I: Preliminary Information

Personal Profile

Last Name: ________________________________ **Date:** ________________

First Name: ________________________________ **Date of Birth:** ___________

Part II: Cholesterol Drugs and Symptoms

Please write neatly and clearly. Fill out as completely as possible.

1. **How would you compare your memory before taking any cholesterol medications with the memory of other people your same age?**

Please place an "X" on the line below to indicate memory as compared to others your age.

|---------------------------------|---------------------------------|

Much Worse — **The Same** — **Much Better**

A. FIRST CHOLESTEROL DRUG

Please answer the following questions about your first cholesterol drug:

2. **Name of first cholesterol drug:** ____
3. **Dose of first cholesterol drug:** ____
4. **Duration of use of first cholesterol drug:** ______________________________________
5. **Date of use of first cholesterol drug:** ____

6. **Your cholesterol values on the first drug and dose (if known):**

	Before this drug	On this drug
Date of measurement		
Total cholesterol (mg/dl)		
LDL (mg/dl)		
HDL (mg/dl)		
Triglycerides (mg/dl)		

7. **Did you develop symptoms of memory/thinking problems on the first drug?**
   Yes____ No _____

If you answered no to the prior question, please move on to page 4, "Second Cholesterol Drug".

8. **How long after starting this drug did you *first notice symptoms* of memory/ thinking problems?**
   ________ ☐ **Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)**
   (number)

Please go on to the next page ->

9. How long after starting the first drug were the symptoms *at their worst* ?
________ □ Day(s) / □ Week(s) / □ Month(s) / □ Year(s)
(number)

10. How long did you stay on the first drug after symptoms began?
________ □ Day(s) / □ Week(s) / □ Month(s) / □ Year(s)
(number)

If you experienced any memory loss or difficulty in making decisions while on this medication please place an "X" on the line(s) below that shows the severity of your symptoms at its WORST. Check N/A (not applicable) if you never experienced the indicated symptom.

11. How would you rate the severity of the symptoms at their worst?

Memory: |--|
No Memory Loss ... **Complete Memory Loss** □ **N/A**

Ability to successfully perform, complete or navigate real world tasks: |--|
Complete Inability ... **Normal Ability** □ **N/A**

Memory compared to others your age: |---------------------------------|---------------------------------|
Worse ... **The Same** ... **Better** □ **N/A**

12. Did the symptoms lessen with continued use of the first drug?
Yes____ No _____
Comments:

13. Are you still taking the first drug? Yes____ No ____

If you answered "yes" the prior question, please move on to Part III on page 11 .

14. If you stopped the drug, how long after noticing the symptom(s) did you stop taking the first drug?
________ □ Day(s) / □ Week(s) / □ Month(s) / □ Year(s)
(number)

15. If you stopped the first drug, answer the following:

a. How long was it before you *first* noticed improvement in symptom(s)? ________________
b. How long was it before *maximum* improvement in symptoms(s)? ____________________
c. How long has it been since you stopped taking the first drug?
________ □ Day(s) / □ Week(s) / □ Month(s) / □ Year(s)
(number)

Please go on to the next page ->

16. Check one of the following:

a. ☐ You switched to a new cholesterol drug, or different dosage, without time to assess improvement?

- ☐ **<u>Without time off</u> the first drug**
- ☐ **<u>With time off</u> the first drug, but before recovery was complete**
  - **Time off was:**

    _____ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
    (number)

If you checked "16a", please go on to the next drug on page 4.

b. ☐ No improvement occurred after stopping this drug.

c. ☐ The problem got worse after stopping this drug.

d. ☐ Improvement occurred after stopping this drug

If you checked "16d", please complete #17. Otherwise go on to #18.

17. How complete was your recovery? Check all that apply.

a. ☐ Complete recovery occurred. Recovery was complete after:

________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

b. ☐ Improvement is ongoing now, after stopping this drug for:

________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

c. ☐ Partial recovery occurred after stopping the drug for:

________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

18. Your cholesterol values after stopping the first drug (if known):

	Off this drug
Date of measurement	
Total cholesterol (mg/dl)	
LDL (mg/dl)	
HDL (mg/dl)	
Triglycerides (mg/dl)	

Please go on to the next page ->

19. At maximum recovery, what were the levels of recovery for your memory and/or thinking problems? Please mark an "X" on the scales below indicating how much you felt you recovered from the symptom. Check N/A (not applicable) if you never experienced the indicated symptom.

Memory: |--|
No Recovery **Complete Recovery** ☐ **N/A**

Ability to successfully complete/navigate real world tasks: |--|
No Recovery **Complete Recovery** ☐ **N/A**

Memory compared to others your age: |---------------------------------|---------------------------------|
Much Worse **The Same** **Much Better** ☐ **N/A**

DID YOU TAKE ANOTHER DRUG OR CHANGE THE DOSE?
IF YES, CONTINUE. IF NO, MOVE ON TO PART III, PAGE 11.

B. SECOND CHOLESTEROL DRUG

Please answer the following questions about your second cholesterol drug:

20. Name of second cholesterol drug: ____
21. Dose of second cholesterol drug: ____
22. Duration of use of second cholesterol drug: _____________________________________
23. Date of use of second cholesterol drug: ____

24. Please complete the following:

	Before this drug	On this drug
Date of measurement		
Total cholesterol (mg/dl)		
LDL (mg/dl)		
HDL (mg/dl)		
Triglycerides (mg/dl)		

25. Did you develop symptoms of memory/thinking problems on the second drug?
Yes____ No _____

If you answered no to the prior question, please move on to page 7, "Third Cholesterol Drug".

26. How long after starting this drug did you *first notice symptoms* of memory/ thinking problems?
________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

27. How long after starting the second drug were the symptoms *at their worst* ?
________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

28. How long did you stay on the second drug after symptoms began?

________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

If you experienced any memory loss or difficulty in making decisions while on this medication please place an "X" on the line(s) below that shows the severity of your symptoms at its WORST. Check N/A (not applicable) if you never experienced the indicated symptom.

29. How would you rate the severity of the symptoms at their worst?

Memory: |---|
No Memory Loss ... **Complete Memory Loss** ☐ **N/A**

Ability to successfully perform, complete, or navigate real world tasks: |---|
Complete Loss of Ability ... **No Loss of Ability** ☐ **N/A**

Memory compared to others your age: |---------------------------------|---------------------------------|
Much Worse ... **The Same** ... **Much Better** ☐ **N/A**

30. Did the symptoms get better with continued use of the second drug?
Yes____ No _____
Comments:

31. Are you still taking the second drug?
Yes____ No ____

If you checked"yes" to the prior question, please move on to Part III on page 11.

32. If you stopped the drug, how long after noticing the symptom(s) did you stop taking the second drug?
________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

33. If you stopped the second drug, answer the following:
a. How long was it before you *first* noticed improvement in symptom(s)__________________
b. How long was it before *maximum* improvement in symptoms(s) ______________________
c. How long has it been after you stopped the second drug?
________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

Please go on to the next page ->

34. Check one of the following:

a. ☐ You switched to a new cholesterol drug, or different dosage, without time to assess improvement?

- ☐ **<u>Without time off</u> the first drug**
- ☐ **<u>With time off</u> the first drug, but before recovery was complete**
  - **Time off was:**

    _____ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)

If you checked "34a", please go on to the next drug on page7.

b. ☐ No improvement occurred after stopping this drug.

c. ☐ The problem got worse after stopping this drug.

d. ☐ Improvement occurred after stopping this drug

If you checked "34d", please complete #35. Otherwise, go on to #36.

35. How complete was your recovery? Check all that apply.

a. ☐ Complete recovery occurred. Recovery was complete after:

________ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)

b. ☐ Improvement is ongoing now, after stopping this drug for:

________ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)

c. ☐ Partial recovery occurred after stopping the drug for:

________ (number) ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)

36. Your cholesterol values after stopping the second drug (if known):

	Off this drug
Date of measurement	
Total cholesterol (mg/dl)	
LDL (mg/dl)	
HDL (mg/dl)	
Triglycerides (mg/dl)	

Please go on to the next page ->

37. At maximum recovery, what were the levels of recovery for your memory and/or thinking problems? Please mark an "X" on the scales below indicating how much you felt you recovered from the symptom. Check N/A (not applicable) if you never experienced the indicated symptom.

Memory: |--|
No Recovery **Complete Recovery** ☐ **N/A**

Ability to successfully perform, complete or navigate real world tasks: |--|
No Recovery **Complete Recovery** ☐ **N/A**

Memory compared to others your age: |---------------------------------|---------------------------------|
Much Worse **The Same** **Much Better** ☐ **N/A**

DID YOU TAKE ANOTHER DRUG OR CHANGE THE DOSE?
IF YES, CONTINUE. IF NO, MOVE ON TO PART III, PAGE 11.

C. THIRD CHOLESTEROL DRUG

Please answer the following questions about your <u>third</u> cholesterol drug.

38. Name of third cholesterol drug: ____
39. Dose of third cholesterol drug: ____
40. Duration of use of third cholesterol drug: ____
41. Date of use of third cholesterol drug: ____

42. Please complete the following table:

	Before this drug	On this drug
Date of measurement		
Total cholesterol (mg/dl)		
LDL (mg/dl)		
HDL (mg/dl)		
Triglycerides (mg/dl)		

43. Did you develop symptoms of memory/thinking problems on the third drug?
Yes____ No _____

If you answered <u>no</u> to the prior question, please move on to Part III on page 11.

44. How long after starting this drug did you *first notice symptoms* of memory/thinking problems?
________ ☐ **Day(s)** / ☐ **Week(s)** / ☐ **Month(s)** / ☐ **Year(s)**
(number)

45. How long after starting the third drug were the symptoms *at their worst*?
________ ☐ **Day(s)** / ☐ **Week(s)** / ☐ **Month(s)** / ☐ **Year(s)**
(number)

Please go on to the next page ->

46. How long did you stay on the third drug after symptoms began?

________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

If you experienced any memory loss or difficulty in making decisions while on this medication please place an "X" on the line(s) below that shows the severity of your symptoms at its WORST. Check N/A (not applicable) if you never experienced the indicated symptom.

47. How would you rate the severity of the symptoms at their worst?

Memory: |---|
No Memory Loss — **Complete Memory Loss** ☐ **N/A**

Ability to successfully perform, complete, or navigate real world tasks: |---|
Complete Loss of Ability — **No Loss of Ability** ☐ **N/A**

Memory compared to others your age: |-----------------------------------|-----------------------------------|
Much Worse — **The Same** — **Much Better** ☐ **N/A**

48. Did the symptoms get better with continued use of the third drug?
Yes____ No _____
Comments:

49. Are you still taking the third drug?
Yes____ No ____

If you answered "yes" to the prior question, please move on to Part III on page 11.
If you answered "no", but do not have other cholesterol-lowering drug(s) to report, please also move on to Part III on page 11.
If you answered "no" to the prior question and have other cholesterol-lowering drug(s) to report, please contact the UCSD Statin Study for additional sheets: (858) 558-4950 x215.

50. If you stopped the drug, how long after noticing the symptom(s) did you stop taking the third drug?
________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

51. If you stopped the third drug, please answer the following:
a. How long was it before you *first* noticed improvement in symptom(s)___________________
b. How long was it before *maximum* improvement in symptoms(s) _______________________
c. How long has it been after you stopped the third drug?
________ ☐ Day(s) / ☐ Week(s) / ☐ Month(s) / ☐ Year(s)
(number)

Please go on to the next page ->

52. Check one of the following:

a. ☐ You switched to a new cholesterol drug, or different dosage, without time to assess improvement?

- ☐ **Without time off the first drug**
- ☐ **With time off the first drug, but before recovery was complete**
  - **Time off was:**

    _____ (number) ☐ **Day(s)** / ☐ **Week(s)** / ☐ **Month(s)** / ☐ **Year(s)**

If you checked "52a", please call to request additional formatted sheets for additional drug/change of dosage from the UCSD Statin Study: (858) 558-4950 x215.

b. ☐ No improvement occurred after stopping this drug.

c. ☐ The problem got worse after stopping this drug.

d. ☐ Improvement occurred after stopping this drug

If you checked "52d", please complete #53. Otherwise, go on to #54.

53. How complete was your recovery? Check all that apply.

a. ☐ Complete recovery occurred. Recovery was complete after:

________ (number) ☐ **Day(s)** / ☐ **Week(s)** / ☐ **Month(s)** / ☐ **Year(s)**

b. ☐ Improvement is ongoing now, after stopping this drug for:

________ (number) ☐ **Day(s)** / ☐ **Week(s)** / ☐ **Month(s)** / ☐ **Year(s)**

c. ☐ Partial recovery occurred after stopping the drug for:

________ (number) ☐ **Day(s)** / ☐ **Week(s)** / ☐ **Month(s)** / ☐ **Year(s)**

54. Your cholesterol values after stopping the third drug (if known):

	Off this drug
Date of measurement	
Total cholesterol (mg/dl)	
LDL (mg/dl)	
HDL (mg/dl)	
Triglycerides (mg/dl)	

Please go on to the next page ->

55. At maximum recovery, what were the levels of recovery for your memory and/or thinking problems? Please mark an "X" on the scales below indicating how much you felt you recovered from the symptom. Check N/A (not applicable) if you never experienced the indicated symptom.

Memory: |---|
No Recovery **Complete Recovery** ☐ **N/A**

Ability to successfully complete/navigate real world tasks: |---|
No Recovery **Complete Recovery** ☐ **N/A**

Memory compared to others your age: |----------------------------------|---------------------------------|
Much Worse **The Same** **Much Better** ☐ **N/A**

If you stopped the third drug and have other cholesterol-lowering medication(s) to report, please request additional formatted sheets from the UCSD Statin Study: (858) 558-4950 x215.

Please go on to the next page ->

Part III: Memory and Thinking Related Symptoms

Check "yes" or "no" to each of the following symptoms if you noticed it for the first time while on cholesterol-lowering medications or if it seemed to worsen while on this/these drug(s). Please provide any additional comments at the end of the questionnaire.

Symptom	*Occurred or Worsened on cholesterol drugs* (e.g. Y_x_N__)	*Degree of Worsening:* 0=not present 10=most severe	*Degree of Improvement off Statins:* 0=no improvement 10=complete recovery to pre-cholesterol drug use	*Describe*
Trouble with name recall of friends or acquaintances	**Y ___N___**			
Forget names of family members	**Y ___N___**			
Trouble finding words	**Y ___N___**			
Trouble completing sentences	**Y ___N___**			
Getting lost listening (e.g. cannot recall the beginning of a story you are telling, or your intended point)	**Y ___N___**			
Talking filled with pauses	**Y ___N___**			
Forgetting what you were going to say	**Y ___N___**			
Trouble with a foreign or second language	**Y ___N___N/A__**			
Saying things that are wrong or do not make sense	**Y ___N___**			
Other language problems	**Y ___N___**			
Trouble with addition (e.g. managing a checkbook)	**Y ___N___**			
Mixing up number order	**Y ___N___**			
Trouble with calculations	**Y ___N___**			
Other number problems	**Y ___N___**			
Forget where you were going (or why you went there): **1) in the house** **2) outside the house**	**1) Y ___N___** **2) Y ___N___**			
Getting lost	**Y ___N___**			
Total disorientation	**Y ___N___**			
Other spatial problems	**Y ___N___**			
Trouble with everyday tasks	**Y ___N___**			
Forget having been somewhere recently	**Y ___N___**			
Trouble coordinating or performing complex tasks	**Y ___N___**			
Amnesia episodes, lost time, or "blanking out"	**Y ___N___**			
Trouble coordinating thoughts	**Y ___N___**			
Trouble recalling numbers you used to remember easily	**Y ___N___**			
OTHER ***(Please describe):*** ***If needed, continue on page 15***	**Y ___N___**			

Please go on to the next page ->

Part IV: Effects of Symptoms and Doctor's Response

This part of the questionnaire will help us to understand how these symptoms affect people's lives and how doctors respond to concerns about these symptoms.

1. Did anything seem to make your memory/cognitive symptoms better?
If so, describe:

2. Did anything seem to make your memory/cognitive symptoms worse?
If so, describe:

3. Did you see your doctor about your memory/cognition symptoms?
Yes____ No _____
What type of doctors did you see (family care, neurologist, etc.)?
Describe:

4. Did your doctor fully appreciate the impact of the memory/cognition symptoms on your well-being?
Yes____ No _____
Comments:

5. Did you talk to your doctor about the possibility of a link between your use of cholesterol drug(s) and symptoms affecting your memory/cognition?
Yes____ No _____ If yes, who brought it up? You did ____ Your doctor did____
Comments:

6. If cholesterol drug use was discussed in relation to memory/cognition symptoms, what was your doctor's approach to the possible link between cholesterol drug(s) and your symptoms?
Endorsed/Supported_____ Dismissed_____ Was Neutral_____

7. What tests were done (x-rays, blood tests, brain MRI, CAT scan, EEG, neuropsychiatric evaluation, others)?
___Blood Tests: _________________ Results: ____________________________
___Other________________________ Results: ___________________________
___Other________________________ Results: ___________________________
(Note: your consent to release information will help us greatly if tests were done.)

8. Did your doctor give a cause or diagnosis for your change in memory/cognition?
Yes____ No _____
If so, what:

Please go on to the next page ->

9. Did you receive any treatments from your doctor for these symptoms?
Yes____ No _____

If you answered "no", please move on to Question #11

10. If you received treatments from your doctor for these symptoms, please list the treatments below, place and "X" on the line to indicate how much the treatment helped, and comment on the effect. Please include dose and duration of treatment use.

Treatment (include dose and duration):	Maximum Possible Worsening	No effect	Maximum Possible Improvement	Comment on Effect
a. _______________	|-----------------------------|		-----------------------------|	_______________
b. _______________	|-----------------------------|		-----------------------------|	_______________
c. _______________	|-----------------------------|		-----------------------------|	_______________
d. _______________	|-----------------------------|		-----------------------------|	_______________
e. _______________	|-----------------------------|		-----------------------------|	_______________
f. _______________	|-----------------------------|		-----------------------------|	_______________
	-10	0	+10	

11. Did you try any other treatment such as other medicine, over-the-counter drugs, herbal supplements, "alternative medicine" or therapy? Yes__ No__

If you answered "no", please move on to Question #13

12. If you tried treatments such as other medicines, over-the-counter drugs, herbal supplements , "alternative medicine" or therapy, please list the treatments below, place an "X" on the line to indicate how much the treatment helped, and comment on the effect. Please include dose and duration of treatment use.

Treatment (include dose and duration):	Maximum Possible Worsening	No effect	Maximum Possible Improvement	Comment on Effect
a. _______________	|-----------------------------|		-----------------------------|	_______________
b. _______________	|-----------------------------|		-----------------------------|	_______________
c. _______________	|-----------------------------|		-----------------------------|	_______________
d. _______________	|-----------------------------|		-----------------------------|	_______________
e. _______________	|-----------------------------|		-----------------------------|	_______________
f. _______________	|-----------------------------|		-----------------------------|	_______________
	-10	0	+10	

Personal Medical History

13. Have you ever had a head injury with loss of consciousness?
Yes____ No_____

14. Do you take medications that can affect memory (e.g. Beta blockers, benzodiazepines, etc)?
Yes____ No_____

Please go on to the next page ->

15. Have any first degree relatives had Alzheimer's (i.e. biological parent/sibling/child)?
Yes____ No _____

16. Have you had any other health condition that you suspect may have contributed to your memory loss?
Yes____ No_____
If yes, please describe:

17. Have you had past significant exposure to pesticides or solvents?
Yes____ No____
Describe:

18. How did the memory/cognition symptoms that you experienced on cholesterol drugs affect you?
Please place an "X" on the lines below:

	Maximal Possible Worsening	No Effect	Maximal Possible Improvement	
Overall quality of life	|---------------------------------|---------------------------------|			☐ N/A
Emotional state/mood	|---------------------------------|---------------------------------|			☐ N/A
Family activities/function	|---------------------------------|---------------------------------|			☐ N/A
Social activities/function	|---------------------------------|---------------------------------|			☐ N/A
Occupational function	|---------------------------------|---------------------------------|			☐ N/A
Household function	|---------------------------------|---------------------------------|			☐ N/A
Recreational activities	|---------------------------------|---------------------------------|			☐ N/A
Other (specify): __________	|---------------------------------|---------------------------------|			☐ N/A
	-10	**0**	**+10**	

(Mark "N/A" next to any that do not apply – e.g. occupational function for persons who are retired)

19. Please record your most recent cholesterol levels in the table below:

	Date of record	**Value (mg/dL)**
Total cholesterol (mg/dl)		
LDL (mg/dl)		
HDL (mg/dl)		
Triglycerides (mg/dl)		

Please go on to the next page ->

Part V: Additional Comments

This part of the questionnaire is very important, and provide the opportunity to add any additional comments about your experience or how it affected you. Include any detail you think may be relevant. We are interested in all you would like to share with us. Please use the additional space provided to attach additional pages if needed. We sincerely thank you for your time and effort.

Please send this questionnaire and the consent form to:
University of California, San Diego
Statin Study
9500 Gilman Drive 0995
La Jolla, CA 92093-0995

End. Thank you.

The Cognitive Failures Questionnaire (Broadbent, Cooper, FitzGerald & Parkes, 1982)

The following questions are about minor mistakes which everyone makes from time to time, but some of which happen more often than others. We want to know how often these things have happened to your in the past 6 months. Please circle the appropriate number.

		Very often	Quite often	Occasion-ally	Very rarely	Never
1.	Do you read something and find you haven't been thinking about it and must read it again?	4	3	2	1	0
2.	Do you find you forget why you went from one part of the house to the other?	4	3	2	1	0
3.	Do you fail to notice signposts on the road?	4	3	2	1	0
4.	Do you find you confuse right and left when giving directions?	4	3	2	1	0
5.	Do you bump into people?	4	3	2	1	0
6.	Do you find you forget whether you've turned off a light or a fire or locked the door?	4	3	2	1	0
7.	Do you fail to listen to people's names when you are meeting them?	4	3	2	1	0
8.	Do you say something and realize afterwards that it might be taken as insulting?	4	3	2	1	0
9.	Do you fail to hear people speaking to you when you are doing something else?	4	3	2	1	0
10.	Do you lose your temper and regret it?	4	3	2	1	0
11.	Do you leave important letters unanswered for days?	4	3	2	1	0
12.	Do you find you forget which way to turn on a road you know well but rarely use?	4	3	2	1	0
13.	Do you fail to see what you want in a supermarket (although it's there)?	4	3	2	1	0
14.	Do you find yourself suddenly wondering whether you've used a word correctly?	4	3	2	1	0
15.	Do you have trouble making up your mind?	4	3	2	1	0
16.	Do you find you forget appointments?	4	3	2	1	0
17.	Do you forget where you put something like a newspaper or a book?	4	3	2	1	0
18.	Do you find you accidentally throw away the thing you want and keep what you meant to throw away – as in the example of throwing away the matchbox and putting the used match in your pocket?	4	3	2	1	0
19.	Do you daydream when you ought to be listening to something?	4	3	2	1	0
20.	Do you find you forget people's names?	4	3	2	1	0
21.	Do you start doing one thing at home and get distracted into doing something else (unintentionally)?	4	3	2	1	0
22.	Do you find you can't quite remember something although it's "on the tip of your tongue"?	4	3	2	1	0
23.	Do you find you forget what you came to the shops to buy?	4	3	2	1	0
24.	Do you drop things?	4	3	2	1	0
25.	Do you find you can't think of anything to say?	4	3	2	1	0

Cognitive Failures Questionnaire-for-Others (To be filled out by a relative or partner)

The questions given below are about mistakes and difficulties which everybody has from time to time. We want to know how often, in your opinion, your relative or partner has shown any of these troubles during the last six months. After each question please tick only one of the five possible answers. Please make sure you read them carefully because for some of the questions 'very often' is on the left side of the page and 'never' is on the right, for other questions 'never is on the left and 'very often' is on the right.

During the last six months has your relative or partner seemed to be:

1. Absent-minded, that is making mistakes in what he/she is doing because he/she is thinking of something else?
   Very often   Quite often   Occasionally   Very rarely   Never

2. Finding it difficult to concentrate on anything because his/her attention tends to wander from thing to another?
   Never   Very rarely   Occasionally   Quite often   Very often

3. Forgetful, such as forgetting where he/she has put things, or about appointments, or about what he/she has done?
   Very often   Quite often   Occasionally   Very rarely   Never

4. Busy thinking about his/her own affairs and so not noticing what is going on around him/her?
   Never   Very rarely   Occasionally   Quite often   Very often

5. Clumsy, for example, dropping things or bumping into people?
   Very often   Quite often   Occasionally   Very rarely   Never

6. Having difficulty in making up his/her mind?
   Never   Very rarely   Occasionally   Quite often   Very often

7. Disorganized, that is, getting into a muddle when doing something because of lack of planning or concentration?
   Very often   Quite often   Occasionally   Very rarely   Never

8. Getting unduly cross about minor matters?
   Never   Very rarely   Occasionally   Quite often   Very often

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References

Broadbent, D.E., Cooper, P.F., FitzGerald, P., & Parkes, K.R. (1982). The Cognitive Failures Questionnaire (CFQ) and its correlates. *British Journal of Clinical Psychology*, *21*, 1-16.