Patient Name: _____ Date: _____

WIEN CENTER
NEW PATIENT QUESTIONNAIRE

THIS FORM SHOULD BE FILLED OUT EITHER BY THE PATIENT OR BY ANOTHER PERSON, WHOEVER CAN PROVIDE THE MOST ACCURATE INFORMATION

I. DEMOGRAPHIC INFORMATION

PATIENT NAME: _____ Date: (of appointment) _____
Address: _____ Apt#: _____
City: _____ State: _____ Zip:_____ Country: _____
Telephone: _____ Date of birth: mm_____ dd_____ yy_____ Age: _____
Social Security #: _____ Male _____ Female_____
Place of Birth: (City) _____ (State) _____ (Country)_____
If Born Outside the U.S., (when did you come to live in the U.S.) year: _____ Year arrived in Florida _____
Are you: ____ Right Handed ___ Left Handed ___ Ambidextrous (Right & Left)
EMAIL ADDRESS:_____

CAREGIVER OR NEXT OF KIN: _____
First Middle Last
Address: _____ Apt#: _____
City: _____ State: _____ Zip:_____ Tel: _____
Relationship to patient: _____ Date of Birth:_____ Place of Birth: _____

PRIVATE PHYSICIAN NAME: _____
Address: _____ City/Zip: _____
Telephone: _____ Fax: _____

Please answer the following questions:

A. LANGUAGE:

What is your primary language? (Language with which you are most comfortable)
___ English ___ German ___ Other (Specify) _____
___ Spanish ___ French/Creole

Do you speak another language? ___ No ___ Yes
If yes, specify languages: _____

What language did you first learn to speak? _____

B. EDUCATION:

What is the total number of years of education you received? (e.g. 8 yrs., 12 yrs.) _____
Please provide the number of years for each level in the space provided. (e.g. High School = 4)

Grade School ____ High School ____ College/University ____
MD/Ph.D. ____ Other (Specify)_____

Patient Name: _____ Date: _____

C. OCCUPATION:

What is the most responsible position you ever had? _____

If retired, when (year or how long ago) _____

D. RACE/SOCIO-CULTURAL BACKGROUND: (check one)

a. ___ White: ___ English speaking ___ Spanish-speaking

b. ___ Black: ___ African American ___ English-speaking ___ Spanish-speaking ___ Creole

c. ___ Asian/Pacific Islander

d. ___ Other: (Specify) _____

E. RELIGION: (check one) ___ Jewish ___ Catholic ___ Other (specify): _____

F. MARITAL STATUS: (check one) ___ Married ___ Separated ___ Widowed ___ Single ___ Divorced ___ Committed Relationship

# of Marriages	# of years Married	# of years Widowed	# of years Divorced

G. CURRENT LIVING SITUATION: (check one)

___ Alone ___ With Spouse/Significant Other ___ With Children/Child ___ With Other Relatives
___ In a Facility (ALF, Retirement Home, Etc.) ___ Other (please specify)_____

HAVE YOU EVER BEEN EVALUATED FOR MEMORY LOSS? ___ NO ___ YES

If yes, where or by whom? _____
What were the results? _____
_____

HAVE YOU HAD ANY OF THESE TESTS DONE? (check **ALL** that apply):

___ CT or MRI of the brain ___ EEG ___ Neurological Exam
___ Psychiatric Exam ___ Neuropsychological testing

(If any of the above have been done please bring the reports and films, if possible, for this evaluation).

Patient Name: _____ Date: _____

This form should be filled out either by the patient or by another person, whoever can provide the most accurate information.

Completed By: _____ Relationship to Patient: _____

II. FAMILY HISTORY

Enter information for ALL of the following relatives: PARENTS, SISTERS, BROTHERS and CHILDREN

Enter other relatives such as uncles, aunts, and grandparents, ONLY if they are affected with memory or other cognitive problems.

Check under **Memory Loss Column**, if the relative had Alzheimer's disease, "senility", "arteriosclerosis," "dementia" or any similar illness affecting memory. If memory loss is/was present, write in number of year's duration.

Name	Relationship	Living	Dead	Present Age or Age at Death	Cause of Death	Memory Loss or cognitive problems (Y/N) Duration
	Mother					
	Father					

Add additional sheets if necessary.

Has anyone in your family had **DOWN SYNDROME**? ___ Yes ___ No
Has anyone in your family had **MENTAL RETARDATION**? ___ Yes ___ No

If YES, Please state who & how he/she is related to you. _____

Patient Name: _____ Date: _____

This form should be filled out either by the patient or by another person, whoever can provide the most accurate information.

Completed By: _____ Relationship to Patient: _____

III. PATIENT MEMORY ASSESSMENT QUESTIONNAIRE (MAQ)

		Yes	No
A.	Do you have a memory problem?		
B.	Do others tell you that you have a memory problem?		
C.	Do you have other problems such as being able to express yourself or knowing how to do things?		
D.	How long ago did these problems first begin? [in weeks/months/years]		
E.	Did the problems start suddenly or gradually?		
F.	After the problems became noticeable, did they worsen or stay at the same level?		
G.	Is there fluctuation or variability from day to day or within one day? Do symptoms get worse and better?		
H.	Have these problems caused you to be unable to function as you previously did?		

Please indicate the correct number as follows: **0=None; 1=Occasionally, 2=Frequently, 3=All the Time**

In recent weeks, months or years, have you or your relatives noticed any of the following symptoms:	**0**	**1**	**2**	**3**
1. Have you started repeating questions or repeating the same story or statement without realizing that you have done so before?				
2. Have you started losing personal possessions (keys, glasses, purse) or forgetting where you have put them?				
3. Have you started forgetting names of friends, relatives, or places?				
4. Have you started having difficulties with finding a word or words you want to use in conversation?				
5. Have you started forgetting to complete what you are doing when you are interrupted?				
6. Do you forget recent events (such as visits to friends, trips taken or important news items) or activities (meals, baths, brushing teeth)?				
7. Have you started making notes and list of things to be done?				
8. Do you have a new problem with finding your way around or knowing how to go somewhere familiar?				
9. Do you have difficulty now with doing chores or using appliances or working controls (e.g. for the TV., stove, washing machine) or playing games (such as cards) that were possible for you previously?				
10. Do you have a new problem with remembering events and facts from many years ago, such as wedding date, first job, school friends or teachers?				
11. Have you recently started having difficulty handling money, knowing how much change to expect, or with handling financial activities, such as writing checks and balancing your bank account?				
12. Do you have difficulty knowing how to put on clothes (Do you misalign buttons or reverse garments or put trousers or arms through sleeves incorrectly)?				
Sum of all Scores				
TOTAL SCORE				

Patient Name: _____ Date: _____

This form should be filled out either by the patient or by another person, whoever can provide the most accurate information.

Completed By: _____ Relationship to Patient: _____

GDS

This questionnaire should be filled out by the patient or by someone else, as long as they consult the patient.

Please answer the following questions. Choose the <u>best</u> answer for how you/the patient have/has felt over the past week:

		YES	NO
1. Are you basically satisfied with your life?	1		
2. Have you dropped many of your activities and interest?	2		
3. Do you feel that your life is empty?	3		
4. Do you often get bored?	4		
5. Are you in good spirits most of the time?	5		
6. Are you afraid that something bad is going to happen to you?	6		
7. Do you feel happy most of the time?	7		
8. Do you often feel helpless?	8		
9. Do you prefer to stay at home, rather than going out and doing a few things?	9		
10. Do you feel you have more problems with memory than most?	10		
11. Do you think it is wonderful to be alive now?	11		
12. Do you feel pretty worthless the way you are now?	12		
13. Do you feel full of energy?	13		
14. Do you feel that your situation is hopeless?	14		
15. Do you think that most people are better off than you are?	15		
TOTAL SCORE			

Comments: _____

_____

_____

_____

Patient Name: _____ Date: _____

This form should be filled out either by the patient or by another person, whoever can provide the most accurate information.

Completed By: _____ Relationship to Patient: _____

IV. MEDICAL INFORMATION/HISTORY

MEDICAL PROBLEMS: Review the following questions and answer **YES** or **NO** to each one, and **CIRCLE** any medical conditions that are listed that apply to you.

Medical Condition	**Yes**	**No**	**I don't Know**
Hearing Problems? Do you wear a hearing aid? Ringing or hissing in the ear(s)			
Visual Problems? Such as: Cataracts, glaucoma, macular degeneration, etc.			
High Blood Pressure (Hypertension) at any time during your life?			
Heart Disease such as: Angina, Heart Attack, Bypass surgery, Valve Problems, Irregular Heart Beat, Pacemaker, Atrial Fibrillation, Arrhythmias			
Diabetes? If yes circle if treated with 1) Diet, 2) pills, 3) insulin, 4) not treated			
Chronic Lung Disease? Such as: Emphysema, Bronchitis, Chronic Asthma; Acute Lung Disease such as Pneumonia, shortness of breath.			
Thyroid Disease? Such as: Underactive or Overactive Thyroid, Goiter, Thyroid nodules, Thyroid Cancer			
Liver Disease? Such as: Hepatitis, Cirrhosis, Liver failure, Jaundice, Liver Cancer			
Kidney Disease? Such as: Kidney Stones, Nephritis, Kidney Failure, Dialysis			
Carotid Stenosis? (Narrowing of the artery in your neck) Indicate which side? Any surgery done?			
Narrowed arteries in the legs (Do not include varicose veins) pain/cramps that occur with walking and relieved with rest. Bypass surgery in the legs			
Stroke? Any weakness of one side of the face, arm or leg or numbness on one side of the body. Any residual problems from the stroke?			
Seizures? Such as: Convulsions, Loss of Consciousness, Jerking Movements of Limbs			
Parkinson's disease or symptoms? Such as: Tremor, stiffness, slowing of movement, Shuffling gait			
History of head injury (even in childhood)? At what age?			
Stomach or Duodenal ulcer, hiatus, hernia, gastric reflux; diverticulitis, polyps of bowel			
Elevated Cholesterol/Lipids? Treatment for high cholesterol/triglycerides?			
Any form of Cancer? Which organ? (Do not include skin cancer other than melanoma)			
Any skin problems? Such as: Psoriasis, Dermatitis, Lupus, Eczema, Chronic Ulcers			
Arthritis? Such as: Osteoarthritis, Rheumatoid arthritis; Gout; which joints?			
(Women) Breast Disease? Such as: Cysts, Cancer, any surgery			
(Women) Was a Hysterectomy done? Were the ovaries taken out as well?			
Osteoporosis (thinning of the bones), fractures and of which bone			
(Men) Prostate Problems? Such as: Enlarged prostate, cancer of prostate?			
Blood Diseases (anemia, leukemia, polycythemia, disorders of clotting/bleeding)			
Other medical problems			

List **All** surgeries and when: (Add additional sheet if necessary).

Surgery _____ Year _____

Surgery _____ Year _____

Surgery _____ Year _____

Patient Name: _____ Date: _____

This form should be filled out either by the patient or by another person, whoever can provide the most accurate information.

REVIEW OF SYSTEMS

Review the following symptoms and answer YES or NO to each one

CONSTITUTIONAL SYMPTOMS	Yes	No
Weight loss (> 5lbs.)		
Weight gain (> 5lbs.)		
Change in appetite		
Fever		
Chills		
Sweating		
Fatigue		

EYES	Yes	No
Loss of vision (Which eye ? _____)		
Glasses or contact lenses		
Blurred vision		
Double vision		
Eye pain		
Red eye		

EARS, NOSE, MOUTH, THROAT	Yes	No
Hearing loss		
Dizziness		
Nasal congestion		
Sinus drainage		
Change in sense of smell		
Mouth sores		
Bleeding gums		
Change in sense of taste		
Painful tongue		
Sore throat		
Hoarseness		
Pain on swallowing		

CHEST (Respiratory)	Yes	No
Cough		
Asthma		
Snoring		
Wheezing		
Painful breathing		
Bloody sputum		

ENDOCRINE	Yes	No
Dryness of skin		
Cold intolerance		
Bulging eyes		
Tremor		
Skin pigmentation		
Change in size of hands, face		
Coarse hair		

HEMATOPETIC/LYMPHATIC	Yes	No
Anemia		
Bleeding		
Lymph node enlargement		
Bruising		
Poor immunity/frequent infections		

CARDIOVASCULAR	Yes	No
Chest pain		
Pacemaker		
Shortness of breath		
Palpitations		
Swelling of Ankles, Feet, or Hands		
Fainting spells		
Pain in legs on walking		
Change in appearance of legs, feet, or hands		

GASTROINTESTINAL	Yes	No
Abdominal pain		
Nausea		
Vomiting		
Heartburn		
Change in bowel habits		
Bleeding from stomach/intestines/rectum		
Constipation		
Diarrhea		

GENITOURINARY	Yes	No
Burning or pain on urination		
Increased frequency of urination		
Urgency of urination		
Poor urinary stream		
Urinary bleeding		
Vaginal bleeding		
Frequent urination at night		
Urinary Incontinence		

SKIN/BREAST	Yes	No
Rash		
Itching		
Sores or lesions		
Painful breasts		
Breast lumps		
Nipple discharge		

Patient Name: _____ Date: _____

MUSCULOSKELETAL	**Yes**	**No**
Joint swelling		
Muscle pain		
Arthritis		
Muscle weakness		
Low back pain		
Neck stiffness/pain		
Difficulty walking		
Falls (with injuries?)		
Assistance required for walking: None___; Cane___; Walker ___ Wheelchair___; Bedridden___		

ALLERGY/IMMUNOLOGIC	**Yes**	**No**
Dermatitis		
Urticaria		
Hay fever		
Eczema		
Angioneurotic edema		

NEUROLOGIC (General)	**Yes**	**No**
Headache		
Vertigo/dizziness, Fainting spells		
Loss of sense of smell		
Double vision		
Blindness of one or both eyes or visual fields		
Weakness of one side of face		
Alteration of voice		
Difficulty with swallowing		
Cerebral stroke/Hemorrhage (weakness/ numbness of one side of the body)		
Seizures (convulsions, epilepsy)		
Imbalance on standing or walking		
Weakness of one or more limbs		
Numbness (lack of sensation) of one or more limbs		
Tremors (At rest only? On action only)		
Involuntary (Jerking)movements		
Difficulty initiating movement		
Slowness of movement		
Loss of sexual interest		
Impotence		
Chronic Pain on any part of the body (State which part affected: _____)		

NEUROLOGIC (Cognitive)	**Yes**	**No**
Word finding problems/Problems with names		
Comprehension Problems (of speech/written materials. Not getting the meaning of questions		
Mispronouncing words, using nonsense words		
Difficulty with reading or writing		
Difficulty with recognizing faces		
Difficulty with reading time on a clock		
Difficulty with noticing/visualizing the environment		
Difficulty with manual skills/using appliances/handling tools or gadgets (e.g. TV remote, microwave)		
Impulsiveness/inappropriateness, childishness		
Euphoria/loss of normal inhibition/overly friendly with strangers		
Loss of initiative/spontaneity, social withdrawal, apathy		
Self neglect (Reluctance to groom /shower /change clothes), Slovenliness		
Inability to plan/predict; disorganization; ritualistic or obsessive behavior		

PSYCHIATRIC HISTORY (or present?)	**Yes**	**No**
Depressed mood		
Anxiety/Nervousness		
Restlessness		
Low energy level/fatigue		
Crying spells		
Pessimism		
Suicidal thoughts/attempts		
Lack of pleasure in any activities		
Paranoia/suspiciousness		
Delusions (false beliefs) (e.g. People are stealing,		
watching me etc.)		
Visual hallucinations – seeing, imagining things		
Auditory hallucinations – hearing things		
Verbal agitation		
Physical agitation		

SLEEP DISORDER	**Yes**	**No**
Difficulty going to sleep		
Difficulty staying asleep		
Waking up too early		
Sleep Apnea		
Problematic snoring		
Nightmares		
Physical Agitation in sleep		
Sleep walking		

Patient Name: _____ Date: _____

This form should be filled out either by the patient or by another person, whoever can provide the most accurate information.

MEDICATION HISTORY (list all the medications you are taking, including over-the counter medication, (vitamin, pain killers, health food store supplements, eye drops, home remedies):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ANTI-INFLAMMATORY DRUGS: Are you taking any of the following medications? (Check **All** that apply)

___ Aspirin ___ Indocin ___ Advil ___ Motrin (Ibuprofen) ___ Alleve (Naprosyn)
___ Prednisone (steroids) ___ Celebrex ___ Vioxx ___ Other anti-inflammatory? (specify) _____

ALLERGIES

Are you allergic to any food or medications? ___ YES ___ NO ___ NOT KNOWN

If YES, please list: _____

Describe the type of allergic reaction: _____

SUBSTANCE USE HISTORY

A. ALCOHOL

Did you ever drink alcoholic beverages? ___ NO ___ YES
a. At what age did you start drinking? _____
b. At what age did you stop drinking? _____

Do you drink now? ___ NO ___ YES
a. How much alcohol did/do you drink? (Check highest amount consumed)

___ Less than 1 drink/month ___ Less than 1 drink/week ___ Less than 1 drink/day
___ 1-2 drinks/day ___ More than 2 drinks/day ___ Heavy drinker

Have you ever had a drinking problem or been treated for alcohol abuse? ___ YES ___ NO

B. SMOKING

Did you ever smoke? ___ NO ___ YES

a. At what age did you start smoking? _____
b. At what age did you stop smoking? _____

Do you smoke now? ___ NO ___ YES

Do/Did you smoke? (check all that apply)

___ Cigarettes ___ Cigars ___ Pipe ___ Chewing Tobacco

How much did/do you smoke? (Check highest amount consumed)

___ Less than 1 pk/wk ___ Less than 1 pk/day ___ About 1 pk/day ___ More than 1 pk/day

Patient Name: _____ Date: _____

C. DRUG

Have you ever abused prescription drugs? ___ YES ___ NO

If yes which ones? _____

Do you use these drugs now? ___ NO ___ YES

Have you ever taken any illegal drugs (e.g. marijuana, cocaine, heroine, crack, etc.) ___ YES ___ NO

Do you take illegal drugs now? ___ NO ___ YES

TOXINS AND CHRONIC INFECTIONS

Have you ever been exposed to any toxins such as arsenic, mercury, lead, manganese, ionizing, radiation, environmental, agricultural or industrial toxins? ___ YES ___ NO

If yes which ones?_____

_____

Have you ever had a chronic infection such as Tuberculosis, Lyme disease, HIV/AIDS, Malaria, Syphilis?

___ YES ___ NO

WOMEN ONLY

MENOPAUSE

1. Have you experienced menopause? ___ NO ___ YES
2. If yes, at what age did Menopause occurs?

If unsure check one: ___ Under 40 ___ 40-45 ___ 45-50 ___ 50-55 ___ 55+

3. Have you had a HYSTERECTOMY (Was the uterus removed)? ____ YES ___ NO
4. Have you had an OOPHORECTOMY (Were both ovaries removed)? ___ YES ___ NO

If yes, How old were you when the hysterectomy/oophorectomy was done? _____

ESTROGEN/HORMONES:

5. Have you ever taken estrogen or other female hormones? ___ NO ___ YES

If yes, check all that apply:

___ Premarin ___ Estradiol ___ Estratab ___ Estrace ___ Estraderm

___ Estracon ___ Estrone ___ Pempro ___ Other (specify)

6. At what age did you start? _____
7. Are you currently taking estrogen? (check one) ___ YES ___ NO

If no, when did you stop? (year) _____

Comments: _____

_____

Additional Information You may Want to Add:

_____

_____

Patient Name: _____ Date: _____

This form should be filled out either by the patient or by another person, whoever can provide the most accurate information.

Completed By: _____ Relationship to Patient: _____

FUNCTIONAL ACTIVITIES QUESTIONNAIRE

Please check the appropriate box. Write the answer to each of the following 12 questions. Make any comments in the space below, identifying the questions by the number for which you are commenting.

	0	1	2	3
Does the patient now have or has had a history of:	**Normal**	**Has Some Difficulty**	**Requires Assistance**	**Totally depends on others**
1. Can the person write checks, pay bills, balance a checkbook?				
2. Can the person assemble tax records, or deal with insurance and other papers?				
3. Can the person shop alone for clothes, household necessities, or groceries?				
4. Can the person play a game of skill, such as a card game or work on a hobby?				
5. Can the person heat water and make a cup of coffee or tea?				
6. Does the person turn off the stove?				
7. Can the person prepare his or her own meals?				
8. Can the person keep track of current events on TV or in the newspaper?				
9. Does the person pay attention, understand, and discuss TV programs, books, and magazines articles?				
10. Does the person remember appointments, family Occasions, holidays and/or medications?				
11. Can the person travel out of the neighborhood Independently?				
12. Can the person drive, arrange to take a bus or train?				
Sum of Scores				
TOTAL SCORE				

Comments: _____

_____

_____

_____

_____

Patient Name: _____ Date: _____

This form should be filled out either by the patient or by another person, whoever can provide the most accurate information.

Completed By: _____ Relationship to Patient: _____

Physical Self Maintenance Scale (PSMS)
Activities of daily Living

Numbers one through five in each category represents worsening stated of function. Circle the number that best describes the patient's functional status. Scores in all six categories should then be totaled. The higher the final scores the greater the degree of impairment.

A.	Toileting	0	Cares for self at toilet completely, no incontinence
		1	Needs to be reminded or needs help in cleaning self, or has rare (weekly at most) accidents
		2	Soiling or wetting while asleep more than once a week
		3	Soiling or wetting while awake more than once a week
		4	No control of bowels or bladder
B.	Feeding	0	Eats without assistance
		1	Eats with minor assistance at mealtimes and/or with special preparation of food, or help in cleaning after meals.
		2	Feeds self with moderate assistance and is untidy
		3	Requires extensive assistance for all meals
		4	Does not feed self at all and resists efforts of other to feed him/her
C.	Dressing	0	Dresses, undresses, and selects clothes from wardrobe
		1	Dresses and undresses self with minor assistance
		2	Needs moderate assistance in dressing or selection of clothes
		3	Needs major assistance in dressing, but cooperates with efforts of others to help
		4	Completely unable to dress self and resist efforts of others to help
D.	Grooming	0	Always neatly dressed, well groomed, without assistance
		1	Grooms adequately with occasional minor assistance, e.g., shaving
		2	Needs moderate and regular assistance or supervision in grooming
		3	Needs total grooming care, but can remain well groomed after help from others
		4	Actively negates all efforts of others to maintain grooming
E.	Physical Ambulation	0	Goes about grounds or city
		1	Ambulates within residence or about one block distance
		2	Ambulates with assistance of (check one) a. ( ) another person b. ( ) railing c. ( ) cane d. ( )walker e. ( )wheelchair – gets in and out without help f. ( ) wheelchair – needs help getting in and out
		3	Sits unsupported in chair or wheelchair, but cannot propel self without help
		4	Bedridden more than half the time
F.	Bathing	0	Bathes self (tub, shower, and sponge bath) without help
		1	Bathes self with help getting in and out of tub
		2	Washes face and hands only but cannot bathe rest of body
		3	Does not wash self but is cooperative with those who bathe him/her
		4	Does not try to wash self, and resists efforts to keep him/her clean
			TOTAL SCORE

Patient Name: _____ Date: _____

THE WIEN CENTER PATIENT REFERRAL FORM

This is important to us to obtain information regarding who referred you to The Wien Center. Therefore, please complete the questions below accurately. Thank you.

Reason for Referral:

Neurological	_____
Evaluation/Consultation, 2nd opinion	_____
Memory Evaluation	_____
Counseling	_____
Psychiatric consultation	_____
Behavioral problems	_____
Psychosocial issues/needs	_____
Drug Study	_____
Brain Bank	_____
Other	_____

How did you hear about The Wien Center:

Physician	_____
Professional (Social Worker, Staff, etc.)	_____
Advertisement (newspaper, professional publication, etc.)	_____
Speaking Engagement, Conference, and/or Exhibit	_____
Free Memory Screening Test	_____
Family	_____
Friend	_____
Word of Mouth (self-referral)	_____
Community Organization/Agency (Alz. Association,	_____
Eldercare, Channeling or other)	_____
Other – please specify:	_____

Specifically, who referred you to The Wien Center:

Dr/Mr/Mrs/or Ms: _____ Profession: _____

Name_____
(Last) (First)

Address: _____

_____

Telephone: _____ Agency: _____

Signature: _____ Relationship to Patient:_____

Patient Name: _____ Date: _____

DIRECTIONS TO MOUNT SINAI MEDICAL CENTER
4300 ALTON ROAD, MIAMI BEACH, FLORIDA 33140
THE WIEN CENTER (305) 674-2543

FROM NORTH:	1-95 TO EXIT 7. 195 EAST TO MIAMI BEACH. AT THE END OF CAUSEWAY TAKE ALTON ROAD NORTH OVER THE OVERPASS. MAKE A LEFT AT FIRST TRAFFIC LIGHT. YOU ARE THERE.
FROM SOUTH:	U.S. 1 TO I-95, NORTH TO EXIT 7. 195 EAST TO MIAMI BEACH AT END OF CAUSEWAY TAKE ALTON ROAD NORTH OVER THE OVERPASS. MAKE A LEFT TURN AT FIRST TRAFFIC LIGHT. YOU ARE THERE
FROM WEST:	836 EAST TO I-95, NORTH TO EXIT 7. 195 EAST TO MIAMI BEACH. AT END OF CAUSEWAY TAKE ALTON ROAD NORTH OVER THE OVERPASS. MAKE A LEFT TURN AT FIRST TRAFFIC LIGHT. YOU ARE THERE.
FROM AIRPORT:	EXIT TO STATE ROAD 112 EAST. GO STRAIGHT TO MIAMI BEACH. AT END OF CAUSEWAY TAKE ALTON ROAD NORTH OVER THE OVERPASS. MAKE A LEFT TURN AT FIRST TRAFFIC LIGHT. YOU ARE THERE.
ON MIAMI BEACH:	GO WEST ON 41ST STREET TO ALTON ROAD. MAKE A RIGHT TURN ON ALTO ROAD AND GO STRAIGHT ACROSS TO HOSPITAL.
THE WIEN CENTER FOR ALZHEIMER'S DISEASE AND MEMORY DISORDER	WE ARE LOCATED ON THE FIRST FLOOR OF THE JAMES L. KNIGHT MRI BUILDING NEXT TO THE EMERGENCY ROOM. PARKING IS LOCATED IN FRONT OF THE MRI BUILDING