INFORMANT REPORT

INSTRUCTIONS: This report is to be completed by the informant. The INFORMANT is defined as the person who gives information about/to another individual.

INFORMATION REGARDING: _____
(Patient's Name)

INFORMANT'S NAME: _____

1. **Your month/year of birth:** _____
2. **Your sex:** **__ Male** **__ Female**
3. **Are you of Hispanic/Latino ethnicity (i.e., having origins from a mainly Spanish-speaking Latin American Country), regardless of race?** **__ Yes** **__ No**
   - If YES, what are your reported origins?

   __ Mexican/Chicano/Mexican-American __ Puerto Rican
   __ Cuban __ Dominican __ Central American
   __ South American __ Other (specify) _____ __ Unknown
4. **What is your race? (Race is defined as a socially meaningful category of people who share biological traits that are obvious and considered important)**

   __ White __ Black/African American __ American Indian or Alaska Native
   __ Asian __ Native Hawaiian or Other Pacific Islander
   __ Other (specify) _____ __ Unknown
5. **Any additional reportable race?**

   __ White __ Black/African American __ American Indian or Alaska Native
   __ Asian __ Native Hawaiian or Other Pacific Islander
   __ Other (specify) _____ __ Unknown
6. **Years of education: How many years of school have you attended? (Include primary through any college attended)** _____
7. **Your relationship to the patient/subject?**

   __ Spouse/partner __ Child __ Sibling
   __ Other relative __ Friend/neighbor __ Paid caregiver/provider
   __ Other (specify) _____
8. **Do you live with the subject?** **__Yes** **__No**
   - If NO, approximate frequency of in-person visits:

   __ Daily __ At least 3x/week __ Weekly
   __ At least 3x/month __ Monthly __ Less than once a month
   - If NO, approximate frequency of telephone contact:

   __ Daily __ At least 3x/week __ Weekly
   __ At least 3x/month __ Monthly __ Less than once a month

ADDTC BEHAVIOR CHECKLIST

Patient Name: _____ Date: _____

Caregiver Name **(person filling out this form):** _____

Relationship to Patient: _____

Do you spend most of every day with the patient?

This questionnaire lists behavior problems or kinds of behavior change. Please place a check mark in the "Present in the Last 6 Months" column to indicate any behavior that has been present in the last six months, even if you don't consider it a problem. Then, for each behavior indicate how often it has been present during the last month. Indicate how often it occurred in the last month as follows:

Never	Has not occurred in the last month.
Rarely	Has occurred once or twice in the last month.
Weekly	Has occurred once a week or every few days.
Daily	Has occurred almost every day or daily
Constantly	Has occurred many times each day.

Was this symptom present in the last six months?	**IF YES** **How often present in last month?**				
	Never	Rarely	Weekly	Daily	Constantly
1. Is forgetful or has poor memory.	____	____	____	____	____
2. Becomes confused or disoriented.	____	____	____	____	____
3. Is easily distracted.	____	____	____	____	____
4. Has problems expressing self verbally.	____	____	____	____	____
5. Gets lost easily.	____	____	____	____	____
6. Talks about feeling sad or depressed.	____	____	____	____	____
7. Is tearful.	____	____	____	____	____
8. Talks about being a failure, inadequate or worthless.	____	____	____	____	____
9. Talks about things s/he has done wrong.	____	____	____	____	____
10. Complains of problems with thinking or concentration.	____	____	____	____	____
11. Says life is not worth living.	____	____	____	____	____
12. Talks about suicide.	____	____	____	____	____
13. Worries too much about little things.	____	____	____	____	____
14. Has episodes of extreme anxiety or panic.	____	____	____	____	____

Was this symptom present in the last six months?	IF YES How often present in last month?				
	Never	Rarely	Weekly	Daily	Constantly
15. Has irrational fear(s) of objects or situations.	___	___	___	___	___
16. Makes inappropriate sexual comments.	___	___	___	___	___
17. Engages in inappropriate sexual behavior.	___	___	___	___	___
18. Displays other embarrasing or inappropriate behavior.	___	___	___	___	___
19. Wanders.	___	___	___	___	___
20. Paces back and forth.	___	___	___	___	___
21. Follows caregiver wherever s/he goes.	___	___	___	___	___
22. Hides or hoards things.	___	___	___	___	___
23. Engages in purposeless activiy.	___	___	___	___	___
24. Repeats same behavior over and over.	___	___	___	___	___
25. Repeats questions or stories.	___	___	___	___	___
26. Is fidgety, can't sit still.	___	___	___	___	___
27. Complains of trouble sleeping.	___	___	___	___	___
28. Has difficulty sleeping at night.	___	___	___	___	___
29. Complains of sleeping too much.	___	___	___	___	___
30. Sleeps too much.	___	___	___	___	___
31. Has increased appetite.	___	___	___	___	___
32. Has poor appetite.	___	___	___	___	___
33. Has gained weight.	___	___	___	___	___
34. Has lost weight.	___	___	___	___	___
35. Is physically violent with other people.	___	___	___	___	___
36. Hits, kicks, or throws objects in anger.	___	___	___	___	___
37. Has verbal outbursts of anger.	___	___	___	___	___
38. Uncooperative with caregiver.	___	___	___	___	___
39. Is irrationally jealous.	___	___	___	___	___
40. Is very suspicious.	___	___	___	___	___
41. Believes others are plotting against or want to hurt her/him.	___	___	___	___	___
42. Has unreal belief that s/he has a serious illness or physical problem.	___	___	___	___	___

Was this symptom present in the last six months?	IF YES How often present in last month?				
	Never	Rarely	Weekly	Daily	Constantly
43. Has unreal belief that her/his body is not working properly.	____	____	____	____	____
44. Has unreal belief that s/he has exceptional powers, talents or abilities.	____	____	____	____	____
45. Believes that people are stealing things from her/him.	____	____	____	____	____
46. Believes spouse or significant other has been unfaithful.	____	____	____	____	____
47. Believes s/he will be abandoned.	____	____	____	____	____
48. Believes that spouse or caregiver is an impostor.	____	____	____	____	____
49. Believes that place s/he is living is not her/his home.	____	____	____	____	____
50. Believes TV shows are real.	____	____	____	____	____
51. Does not recognize own image in mirror.	____	____	____	____	____
52. Does not recognize or misidentifies familiar people.	____	____	____	____	____
53. Sees people or objects that aren't there.	____	____	____	____	____
54. Sees lights or colors that aren't there.	____	____	____	____	____
55. Hears words or voices that aren't there.	____	____	____	____	____
56. Hears sounds that aren't there.	____	____	____	____	____
57. Feels sensations (like being touched) when there's nothing there.	____	____	____	____	____
58. Smells odors that aren't there.	____	____	____	____	____
59. Tastes things that aren't there.	____	____	____	____	____
60. Hears a sound but thinks it is something else (e.g. thinks a phone ring is a siren).	____	____	____	____	____
61. Sees something but thinks it is something else (e.g. thinks a pillow is a person).	____	____	____	____	____
62. Feels a sensation but thinks it is something else (e.g. something thouching her/him).	____	____	____	____	____

Changes in mood and emotion are listed below. Please indicate the degree of each item or how much you have been aware of it, DURING THE LAST MONTH. Use the following guidelines for ratings:

Not Present	The behavior has not been observed.
Mild	The behavior can be seen by someone who is looking for it. It is abnormal, but it is not very intense.If you do something to help, or change the situation, the behavior often will improve.
Moderate	The behavior is easily noticed. Intensity is moderate. The behavior is often seen throughout the day. Changes in the situtation or strong efforts by others to help may improve the behavior a little.
Severe	The behavior is unmistakable. Intensity is high. The behavior may be almost the only thing you notice about the person. Almost nothing helps.

	Not Present	Mild	Moderate	Severe
1. Appears to be sad or depressed.	____	____	____	____
2. Does not seem to enjoy anything.	____	____	____	____
3. Has low energy, becomes tired easily.	____	____	____	____
4. Is nervous, anxious or tense.	____	____	____	____
5. Reacts angrily to minor frustrations.	____	____	____	____
6. Demands must be met immediately.	____	____	____	____
7. Is excitable or impulsive.	____	____	____	____
8. Is agitated or distressed.	____	____	____	____
9. Mood or emotions change quickly and dramatically.	____	____	____	____
10. Has little or no interest in things.	____	____	____	____
11. Does not seem to care about anything.	____	____	____	____
12. Not interested in interacting with others.	____	____	____	____
13. Shows little emotional response.	____	____	____	____
14. Has little sense of humor.	____	____	____	____
15. Is restless or overactive.	____	____	____	____
16. Speaks or moves slowly.	____	____	____	____
17. Shows excessive or inappropriate humor.	____	____	____	____
18. Has craving for sweet foods.	____	____	____	____
19. Thinks slowly.	____	____	____	____

Caregiver Experience Questions

The following questions refer to how you, the caregiver, feel. Please answer these questions about how things have gone for **you** in the last month.

	Never	Rarely	Quite Frequently	Nearly Always
1. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?	____	____	____	____
2. Are you afraid what the future holds for your relative?	____	____	____	____
3. Do you feel downhearted, blue, and sad?	____	____	____	____
4. Do you have crying spells or feel like it?	____	____	____	____
5. Do you get tired for no reason?	____	____	____	____
6. Overall, how burdened do you feel in caring for your relative?	____	____	____	____

Subject Name _____

Informant Name _____

Date _____

CHANGES IN MEMORY AND THINKING

INSTRUCTIONS: This questionnaire is to be completed by the informant regarding the subject named above. Please answer the following:

Memory:

1. Does he/she have a problem with their memory or thinking? ☐ Yes ☐ No

   1a. If yes, is this a consistent problem (as opposed to inconsistent)? ☐ Yes ☐ No

2. Does he/she completely forget a major event (e.g. trip, party, family wedding) within a few weeks of the event?

   ☐ Usually ☐ Sometimes ☐ Rarely

3. Does he/she forget pertinent details of the major event? ☐ Usually ☐ Sometimes ☐ Rarely

Judgment and Problem Solving: How would you rate his/her ability to

1. Solve problems?

   ☐ No Loss ☐ Some Loss ☐ Severe Loss

2. Cope with small sums of money (e.g., make change, leave a small tip)?

   ☐ No Loss ☐ Some Loss ☐ Severe Loss ☐ Not Applicable

3. Handle complicated financial or business transactions (e.g., balance checkbook, pay bills)?

   ☐ No Loss ☐ Some Loss ☐ Severe Loss ☐ Not Applicable

4. Understand situations or explanations?

   ☐ No Loss ☐ Some Loss ☐ Severe Loss

5. Interact with other people in social situations?

   ☐ No Loss ☐ Some Loss ☐ Severe Loss

Community Affairs: These questions relate to the subject's participation in community affairs (such as going to church, visiting friends or family, political activities, professional organizations, social clubs, service organizations, educational programs).

1. Is he/she still working? ☐ Yes ☐ No ☐ Not Applicable

   If not applicable, proceed to item 2

   1a If no longer working, did memory or thinking problems contribute to their decision to retire? ☐ Yes ☐ No

   1b. If still working, do problems with memory and thinking affect their ability to perform on their job? ☐ Yes ☐ No

2. Did he/she ever drive a car? ☐ Yes ☐ No

   If no, proceed to item 3.

   2a. Does he/she drive a car now? ☐ Yes ☐ No ☐ Don't know

   2b. If no longer driving, did memory or thinking problems contribute to the decision not to drive? ☐ Yes ☐ No ☐ Don't know

   2c. If still driving, are there problems or risks because of impaired memory or thinking? ☐ Yes ☐ No ☐ Don't know

3. Is he/she able to go shopping for needs on their own?

   ☐ Rarely or Never (Needs to be accompanied on any shopping trip)

   ☐ Sometimes (Shops for limited number of items; buys duplicate items or forgets needed items)

   ☐ Usually

   ☐ Don't know

   ☐ Not Applicable

4. Is he/she able to carry out activities outside the home on their own?

   ☐ Rarely or Never (Generally unable to perform activities without help)

   ☐ Sometimes (Passive participation in activities)

   ☐ Usually (Actively participates in activities)

   ☐ Don't know

5. Would a casual observer notice that something was wrong with the subject?

☐ Yes ☐ Maybe ☐ Probably Not ☐ Don't know

6. If in a nursing home, does he/she participate in social functions?

☐ Yes ☐ Sometimes ☐ No ☐ Don't know ☐ Not Applicable

Home and Hobbies: These questions relate to changes in homemaking tasks (such as cooking, laundry, grocery shopping, taking out garbage, yard work, simple care maintenance, and basic home repair) and hobbies (such as sewing, painting, handcrafts, reading, entertaining, photography, gardening, going to theater or symphony, woodworking, participation in sports).

1a. What changes have occurred in his/her abilities to perform household chores?

1b. What can he/she still do well?

2a. What changes have occurred in his/her abilities to perform hobbies?

2b. What can he/she still do well?

3a. If in nursing home, what do you think he/she could no longer do well (household chores and hobbies)? If not applicable, skip to next section.

3b. What do you think he/she still could do well?

Personal Care: These questions relate to changes from a previous level of personal care.

What is your estimate of his/her ability in the following areas:

A. Dressing
B. Washing, grooming
C. Eating habits

D. Bladder and bowel control

Medical Record Number _____

GERIATRIC NEUROBEHAVIOR AND ALZHEIMER CENTER
RANCHO LOS AMIGOS REHABILITATION HOSPITAL

Health History Form

DATE: _____

NAME: _____ **AGE**: _____

OCCUPATION: _____ **EDUCATION:** _____

HANDEDNESS: RIGHT _____ LEFT _____

WHO REFERRED YOU TO OUR NEUROLOGY CLINIC?

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

CHIEF COMPLAINT: (Describe the reason you are being seen. If you experienced an injury, please describe how it happened):

PAST MEDICAL HISTORY: (Describe any medical problems you have had in the past or currently have, and the year they were diagnosed):

PAST SURGICAL HISTORY: (Please list all surgeries you have had in the past. List appropriate date, type of surgery, hospital name and doctor's name).

NAME: _____

ALLERGIES:

Are you allergic to any medications? Yes _____ No _____
If yes, please name

_____

_____

_____

SOCIAL HISTORY:

Do you smoke: Yes _____ No _____

If yes, how much? _____

Do you drink alcoholic beverages? Yes _____ No _____

If yes, how often? _____

Do you use “recreational” drugs? Yes _____ No _____

CURRENT MEDICATIONS:

NAME	**DOSAGE (#MG)**	**DIRECTIONS (Frequency)**

HAVE YOU HAD	**DATE PERFORMED**	**LOCATION PERFORMED**
X-Rays		
MRI		
CT Scan		
EMG		
Myelogram		
Bone Scan		

NAME OF PATIENT: _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING AND DATES:

	Approx date		Approx date		Approx date
[ ] Heart trouble	___/___/___	[ ] Thyroid disease	___/___/___	[ ] Blood clots	___/___/___
[ ] High blood pressure	___/___/___	[ ] Migraine	___/___/___	[ ] Elevated cholesterol	___/___/___
[ ] Asthma	___/___/___	[ ] Hepatitis	___/___/___	[ ] Ulcer	___/___/___
[ ] Emphysema	___/___/___	[ ] Liver Disease	___/___/___	[ ] Colitis	___/___/___
[ ] TB	___/___/___	[ ] Gall stones	___/___/___	[ ] Bone disease	___/___/___
[ ] Pneumonia	___/___/___	[ ] Kidney disease	___/___/___	[ ] Back pain	___/___/___
[ ] Pleurisy	___/___/___	[ ] Kidney stones	___/___/___	[ ] Neck pain	___/___/___
[ ] Other lung disease	___/___/___	[ ] Gout	___/___/___	[ ] Eye problems	___/___/___
[ ] Diabetes	___/___/___	[ ] Arthritis	___/___/___	[ ] Ear problems	___/___/___
[ ] Blood transfusion	___/___/___	[ ] Mental illness	___/___/___	[ ] Venereal disease	___/___/___
[ ] Cancer	___/___/___	[ ] Tropical disease	___/___/___		

SYSTEM REVIEW

GENERAL

[ ] Recent weight gain/ amount
[ ] Recent weight loss/ amount
[ ] Fatigue
[ ] Weakness
[ ] Fever

NERVOUS SYSTEM

[ ] Headaches
[ ] Dizziness
[ ] Fainting
[ ] Muscle spasms
[ ] Loss of consciousness
[ ] Sensitivity or pain of hands and/or feet
[ ] Face numbness or tingling
[ ] Muscle weakness
[ ] Muscle tenderness
[ ] Walking difficulty

EARS

[ ] Ringing in ears
[ ] Loss of hearing

EYES

[ ] Pain
[ ] Loss of Vision
[ ] Double or blurred vision
[ ] Dryness
[ ] Feels like something in the eye
[ ] Redness

MOUTH

[ ] Sore tongue
[ ] Bleeding gums
[ ] Sore in mouth
[ ] Loss of taste
[ ] Dryness

THROAT

[ ] Frequent sore throats
[ ] Hoarseness
[ ] Difficulty in swallowing

NECK

[ ] Swollen glands
[ ] Tender glands

HEART & LUNGS

[ ] Pain in chest
[ ] Irregular heart beat
[ ] Sudden changes in heart beat
[ ] Shortness of breath
[ ] Difficulty in breathing at night
[ ] Swollen legs or feet
[ ] High blood pressure
[ ] Heart murmurs
[ ] Cough
[ ] Coughing up blood
[ ] Wheezing
[ ] Night sweats

STOMACH & INTESTINES

[ ] Nausea
[ ] Vomiting of blood or coffee ground material
[ ] Stomach pain relieved by food or milk
[ ] Yellow Jaundice
[ ] Increasing constipation
[ ] Persistent diarrhea
[ ] Blood in stools
[ ] Black stools
[ ] Heartburn

KIDNEY/URINE/BLADDER

[ ] Difficult urination
[ ] Pain or bumming on urination
[ ] Blood in urine
[ ] Cloudy "smoky" urine
[ ] Pus in urine
[ ] Discharge from penis/vagina
[ ] Frequent urination
[ ] Getting up at night to pass urine
[ ] Vaginal dryness
[ ] Rash/ulcers
[ ] Sexual difficulties
[ ] Prostate trouble

PSYCHOLOGY

[ ] Sad/depressed
[ ] Happy/anxious
[ ] Repetitive behavior/habits

ENDOCRINE

[ ] Excessive thirst/hunger
[ ] Nipples discharge

SKIN

[ ] Easy bruising/amount
[ ] Redness
[ ] Rash
[ ] Hives
[ ] Sun Sensitive
[ ] Tightness
[ ] Hair loss
[ ] Nodules/bumps
[ ] Color Changes of hand or feet from the cold

JOINTS/BONES

[ ] Morning stiffness
Lasting how long?
____Hrs ____Min
[ ] Joint pain
[ ] Joint swelling

BLOOD

[ ] Anemia
[ ] Bleeding tendency

NOSE

[ ] Nosebleeds
[ ] Loss of smell
[ ] Dryness

WEIGHT

Has your weight increased, decreased or remained the same in the past 2 years?
[ ] Yes [ ] No
[ ] If no, _____

I have reviewed and confirmed all the information listed above on this page.

_____
Physician's name (Please Print)

_____
Physician's Signature

_____
Date

NAME: _____

FAMILY HISTORY

	If Living		If Deceased,	
	Age	Health (describe any major illness)	Age:	Cause
Mother				
Father				
Sisters				
Brothers				
Children				

Rancho Los Amigos National Rehabilitation Center – University of Southern California
7601 Imperial Hwy, HB1018, STE 7, Downey, CA 90242
PH: (562) 385-8130 • FAX: (562) 803-6900
WWW.Ranchomemoryclinic.org

**** I HEREBY AUTHORIZE:***

Hospital/Organization:			
Physician:			
Address:			
Phone Number:		Fax:	

**** TO RELEASE INFORMATION ON:***

Patient's Name:	
Date of Birth:	

**** FOR THE FOLLOWING MEDICAL RECORDS:***

*** CD DISKS ARE REQUIRED.**

PROGRESS OFFICE NOTES:	
LABS:	
MEDICATION LIST:	
NEUROPSYCH TEST:	
EEG:	
*MRI SCAN - CD DISK & REPORT	
*PET SCAN - CD DISK & REPORT	
*CT SCAN - CD DISK & REPORT	
OTHER:	

**** PLEASE MAIL/FAX TO:***

Veronica Mendez, Clinical Coordinator
Geriatric Neurobehavior and Alzheimers Center
Rancho Los Amigos National Rehabilitation Center
7601 Imperial Hwy. HB1018, STE 7
Downey, CA 90242

FAX: 562-803-6900
PHONE: 562-385-8130

SIGN HERE

Signature of Patient or Authorized Representative: _____

Date: _____

COVID-19 Questionnaire

1) Were you ever known to have tested positive for the COVID-19 virus?

☐ Yes ☐ No

2) Did you ever get sick from infection with the COVID-19 virus?

☐ Yes (go to question 3)
☐ No (skip to question 7)
☐ Not Sure (go to question 3)

3) If so, were you hospitalized for the illness?

☐Yes (go to question 4)

☐ No (skip to question 6)

4) If you were hospitalized, were you admitted to the intensive care unit (ICU)?

☐ Yes (go to question 5)
☐ No (skip to question 6)

5) If you were admitted to the ICU, were you placed on a respirator?

☐ Yes ☐ No

6) If you got sick, which of the following symptoms did you have?

☐Fever and/or Chills ☐ Headache ☐ Loss of Sense of Smell

☐ Cough ☐ Shortness of Breath ☐ Sore Throat

☐Confusion ☐ Sleepiness ☐Diagnosed with a stroke?

☐ Other, Specify _____

7) Have you been vaccinated against infection with COVID-19?

☐ Yes ☐ No

The Memory/Dementia Clinic is partially funded by support through the California Department of Public Health, Alzheimer's Disease Program

Assembly Bill 959 mandates the California Department of Public Health to collect information regarding patients' race/ethnicity and sexual orientation and gender identity in an effort to ensure that our state-funded California Alzheimer's Disease Centers (CADCs) are serving individuals who reflect the diverse population of California, and to address key health policy issues of health disparities and cultural/linguistic competency. All answers are confidential, and you can select the "refuse to state" option if you prefer not to provide this information.

Sexual Orientation/Gender Identity

5. Patient's Sex Assigned at Birth: (22-24)

a) Male .....1 ☐
b) Female .....2 ☐
c) Other (Specify:_____).....3 ☐
d) Refused to provide .....99 ☐
e) Unknown .....999 ☐

6. Patient's Current Gender Identity: (25-27)

a) Male .....1 ☐
b) Female .....2 ☐
c) Trans male.....3 ☐
d) Trans female .....4 ☐
e) Gender queer.....5 ☐
f) Non-binary .....6 ☐
g) Questioning.....7 ☐
h) Unsure .....8 ☐
i) Other (Specify:_____).....9 ☐
j) Refused to provide .....99 ☐
k) Unknown .....999 ☐

7. Sexual Orientation. Do you think of yourself as: | (28-30)

a) Heterosexual or straight .....1 ☐

b) Gay .....2 ☐

c) Lesbian .....3 ☐

d) Bisexual .....4 ☐

e) Queer .....5 ☐

f) Questioning.....6 ☐

g) Unsure .....7 ☐

h) Other (Specify:_____) .....8 ☐

i) Refused to provide .....99 ☐

j) Unknown .....999 ☐

Race/Ethnicity

8A. Hispanic or Latino origin: Are you Hispanic or Latino (ethnic/national origins in any part of Latin America - Cuban, Dominican, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.)? | (31-33)

a) YES **(GO TO Q.8.B)** .....1 ☐

b) NO **(GO TO Q.8.B)** .....2 ☐

c) Refused to state **(GO TO Q.8.B.)** .....99 ☐

d) Unknown (**GO TO Q.8.B)** .....999 ☐

8B. What is your race? (Individuals should choose 1 category of race and/or ethnicity). (34-36)

White .....1 ☐

Black/African American .....2 ☐

Asian:

Asian Indian .....3 ☐

Cambodian .....4 ☐

Chinese .....5 ☐

Filipino .....6 ☐

Japanese .....7 ☐

Hmong .....8 ☐

Korean .....9 ☐

Laotian .....10 ☐

Vietnamese .....11 ☐

Other Asian (Specify:_____) .....12 ☐

Pacific Islander:

Native Hawaiian .....13 ☐

Guamanian .....14 ☐

Samoan .....15 ☐

Other Pacific Islanders (Specify:_____) ..16 ☐

American Indian
[(including North, South and Central American Indian) or Alaska Native (including Aleut and Eskimo)] .....17 ☐

Other Race (Specify:_____).....18 ☐

Multiracial .....19 ☐

Refused to state .....99 ☐

Unknown .....999 ☐