PATIENT HISTORY QUESTIONNAIRE

NEUROBEHAVIOR AND MEMORY HEALTH SERVICE

Patient's Name: _____ Birthdate: _____ Today's Date: _____ Age: _____
Height:_____ Weight: _____

1st Language: _____ Other Language: _____ Preferred Language: _____
Name of person completing form: _____

Describe the problem you are having: _____

_____

When did it start (year and month if possible)? _____
Did it start (circle one) Suddenly Gradually over years Gradually over weeks, months

Over the past year are symptoms (circle one) Worsening Getting Better Staying the same

Have you experienced any of the following symptoms?

Symptom	No	Years Ago	Past Month
Word finding difficulties			
Lose/misplace things			
Repeat conversations/questions			
Get lost in a familiar area			
Distractibility			
Disorganization			
Problems paying attention			
Memory loss/Forgetfulness			
Anxiety			
Depression			
Problems with judgement			
Fevers/chills			
Unexplained weight loss			
Change in appetite (more, less)			
Rash			
Low back pain			
Blood clots in legs or lungs			
Skin or hair changes			
Allergies			
Dry eyes or dry mouth			
Joint pains			
Cough			
Persistent sore throat			

Symptom	No	Years Ago	Past Month
Headaches			
Smell or taste problems			
Loss of vision			
Double vision			
Loss of hearing			
Difficulty swallowing			
Slurred speech			
Difficulty breathing			
Chest pain			
Palpitations			
Constipation			
Urinary urgency/hesitancy			
Difficulty emptying bladder			
Bowel or bladder accidents			
Urinary tract infections			
Numbness in arms or legs			
Weakness in arms or legs			
Trouble walking			
Gait imbalance			
Frequent falls			
Persistent dizziness			
Trouble sleeping			
Sleepiness			

CHECK ALL PREVIOUS DIAGNOSTIC TESTS YOU HAVE HAD AND GIVE DATES WHERE POSSIBLE:

Test	Dates(s)	Test	Dates(s)
MRI Brain	_____	CT Brain	_____
SPECT Brain	_____	PET Brain	_____
Lab Tests	_____	Neurological Exam	_____
Neuropsychological evaluation	_____	EEG	_____
Hospitalization	_____	Sleep Study	_____

PREVIOUS MEDICAL, NEUROLOGIC, PSYCHIATRIC HISTORY:

Please check (☑) each of the following problems that you *have now* or *have had* in the past:

MEDICAL

	Since?		Since?		Since?
☐ AIDS	____	☐ Carpal Tunnel	____	☐ Kidney Disease	____
☐ Anemia	____	☐ Chronic Pain	____	☐ Lung Disease	____
☐ Asthma	____	☐ Diabetes	____	☐ Sexual Dysfunction	____
☐ Arthritis	____	☐ Heart Problem	____	☐ Thyroid Disorder	____
☐ Bodily Injury	____	☐ High Blood Pressure	____	☐ Stomach Problems	____
☐ Cancer/type	____	☐ HIV	____	☐ Vascular Disease	____
☐ High Cholesterol	____	☐ Incontinence	____	☐ Cardiac Surgery	____
☐ Exposure to Toxins	____	☐ Gastric Bypass	____		

☐ Other (please describe):

NEUROLOGICAL

	Since?		Since?		Since?
☐ Alzheimer's	____	☐ Multiple Sclerosis	____	☐ Parkinson's disease	____
☐ ALS	____	☐ Huntington's disease	____	☐ Seizures/epilepsy	____
☐ Encephalitis	____	☐ Meningitis	____	☐ Sleep disorder	____
☐ Head injury	____	☐ Migraine headaches	____	☐ Stroke/TIA	____
With loss of consciousness? Y / N		☐ Movement disorder	____	☐ Syphilis	____

☐ Other (please describe):

PSYCHIATRIC

	Since?		Since?
☐ Alcohol Dependency/Abuse	____	☐ Depression	____
☐ Anxiety Disorder	____	☐ Manic-Depressive (Bipolar) Illness	____
☐ Eating Disorder	____	☐ Psychotic Disorder	____
☐ Drug Dependency/Abuse	____	☐ Other (describe) _____	

FOR WOMEN ONLY

	Since?		
☐ Cystic Breasts	____	☐ Menopause (at what age?_____)	____
☐ Endometriosis/Ovarian Cyst	____	☐ OTHER (describe)	____
☐ Estrogen replacement therapy	____		
☐ Miscarriage			
☐ Hysterectomy (at what age?_____)			

FOR MEN ONLY

☐ Vasectomy (at what age?_____)

CURRENT MEDICATIONS (please include over-the-counter medications):

Name of medication	Dosage(mg/day)	For how long?	What is this medication for?	Prescribed by?

DRUG ALLERGIES: _____

SUBSTANCE USE:

Do you currently drink alcohol? ❒ No ❒ Yes If yes, how much?_____ since when?_____

Have you ever used alcohol regularly in the past? ❒ No ❒ Yes If yes, how much?_____

Do you currently use tobacco? ❒ No ❒ Yes If yes, how much?_____ since when?_____

Have you ever smoked or used tobacco regularly in the past? ❒ No ❒ Yes If yes, how much?_____

Do you currently or have you ever used other (recreational) drugs? ❒ No ❒ Yes If yes, describe?_____

BIRTH/ DEVELOPMENT / ACADEMIC HISTORY:

Highest Academic Degree Completed:_____ When? _____Where?_____

Are you Right Handed? ❒ Left Handed? ❒ Ambidextrous? ❒

Were you born premature? ❒ No ❒ Yes Any complications at birth? ❒ No ❒ Yes

Did your mother have health problems during pregnancy? ❒ No ❒ Yes

Did your mother use alcohol or smoke during pregnancy? ❒ No ❒ Yes

Were you told you were late in learning to talk or walk? ❒ No ❒ Yes

Did you have academic difficulties in elementary school? ❒ No ❒ Yes If yes, check all that apply:

❒ Held back (what grade(s):_____) ❒ Had tutoring ❒ Diagnosed with a learning disability

❒ Had speech therapy ❒ Diagnosed with ADHD

Which subjects did you have trouble with?_____

Did you have any behavioral problems in school? ❒ No ❒ Yes, describe: _____

What was your personality like in elementary school? ❒ Shy ❒ Friendly ❒ Withdrawn

OCCUPATIONAL HISTORY:

Highest Level Occupation Attained: _____ When?_____

Are you working now? ❒ No ❒ Yes If Yes: ❒ full time ❒ part time (no of hrs per week: _____)

If "YES", describe your current job:_____How long at this position? _____

If you are <u>not</u> working, when was your last job?_____ Why did you stop working?_____

Are you currently on disability? ❒ No ❒ Yes

SOCIAL HISTORY:

Which racial and ethnic groups do you identify yourself with?_____

Relationship Status: ❒ Single (never married) ❒ Married ❒ Civil Union ❒ Domestic Partnership

❒ Widowed ❒ Divorced ❒ Separated

Who do you live with? ❒ Alone ❒ Spouse ❒ Child(ren) ❒ Other (describe):_____

Where do you live? ❒ Apartment ❒ Condo ❒ House ❒ Other:_____ For how long?_____

Do you drive? ❒ No (when did you stop? _____) ❒ Yes No of accidents/tickets in the past 5 years?

Who is responsible for the following?	patient	spouse	child	Other
Paying bills/managing financial affairs	❒	❒	❒	❒
Handling medical care, making doctor appointments	❒	❒	❒	❒
Keeping track of medications	❒	❒	❒	❒
Cooking and/or grocery shopping	❒	❒	❒	❒
Repairing things around the house or yard	❒	❒	❒	❒

How do you spend your free time?_____

How many close friends do you have?_____

Who can you call on for social support (for help, when you need a friend to talk to, etc.)?_____

Are you currently involved with any outside agencies or receiving treatment? ❒ No ❒ Yes

If yes, describe:_____

Are you receiving or do you need financial assistance? ❒ No ❒ Yes

Do you have a Power of Attorney for Healthcare? ❒ No ❒ Yes, name:_____

Is this evaluation being requested by an attorney or for legal purposes? ❒ No ❒ Yes

FAMILY HISTORY:

Does anyone in your family have a history of memory problems, dementia, or other neurological conditions?

❒ No ❒ Yes If yes, specify_____

Any history of Alzheimer's disease in your family? ❒ No ❒ Yes Was it autopsy confirmed? ❒ No ❒ Yes

Other family history of medical/neurological/psychiatric problems? _____

Family Member	Living?	Age now or at death	Cause of death	List Medical/Neurological/Psychiatric Problems current or in the past (e.g. high blood pressure, depression)
Mother	Y N			
Father	Y N			
Brothers/Sisters (list):				
	Y N			
	Y N			
	Y N			
	Y N			
Children, Biological only (list):				
	Y N			
	Y N			
	Y N			
	Y N			

Please provide the name, address and telephone number of the physician/s who referred you, if applicable, if you would like to include any other physicians or family members, please bring their information with you to your appointment. ****Also, please provide contact information for your preferred pharmacy.

1. Name: _____

   Address: _____

   City/State/Zip: _____

   Phone: _____

   Fax: _____

2. Name: _____

   Address: _____

   City/State/Zip: _____

   Phone: _____

   Fax: _____

   Pharmacy Name: _____

   Phone: _____

   Fax: _____

   When is your next appointment with the referring physician? _____

Date of Visit: _____ Patient Name:_____

How did you hear about us?

___ **Alzheimer's Association**

___ **Other Community Agency (specify)** _____

___ **Friend or Family Member**

___ **Word of Mouth, Reputation**

___ **Internet**

___ **Support Group (specify)** _____

___ **Conference/Seminar I attended (specify)**_____

___ **Other Source (specify)** _____

___ **My Doctor referred me**

Name: _____
Address: _____
_____

Thank you! Please return this form to the front desk.

Neurobehavior and Memory Health Service
Northwestern Medical Group