CONFIDENTIAL MEDICAL HISTORY

The following information will be helpful for your neuropsychological assessment. Please answer as completely and with as much detail as possible. Feel free to write on the back or to use additional sheets when necessary. Although it is preferred that you complete the information yourself, you may ask a spouse, relative, or significant other for help if needed. Please answer all questions pertaining to you.

Patient Name: ______________________________

Home Address: ____

Telephone: (Home) ____________________________ (Cell) _______________________________

(Significant Other Cell) _________________________________

Referred by: ___________________________________

If another person assisted in filling out this form, please enter the information below:

Name: ____________________________________

Relationship to Patient: ________________________________

GENERAL INFORMATION

Primary Care Doctor: (include name and address) ________________________________

____

Age: _____Date of Birth: ______________ Sex: ___ Height:______ Weight: ______

Circle One: Left- handed Right-handed Mixed

Circle One: Single Married Separated Divorced Widowed

MEDICAL HISTORY

1. Briefly describe what problems (symptoms) caused you to seek help from your current doctor (that lead to referral for testing). ____

2. Approximate date when these problems began:______. Have your symptoms worsened, gotten better, or stayed the same since they first began? ____________________________________
Explain, if necessary: ____

3. To the best of your knowledge, what is the cause of these problems? _________________________

4. What is your understanding of why your doctor referred you for this evaluation?_______________
____

5. Please list all current medications (with dosages), reason you take them, how long you have been on them, and any side effects you have noticed (e.g., nausea, sleepiness, etc.):

Medication	Dosage	Reason	How Long?	Side Effects?

6. List below the names of doctors who currently are treating you.
Name Address Type of Doctor (Family, Neurologist, Internist, Psychiatrist)

____
____
____
____
____
____
____

7. List below all prior hospitalizations, along with dates, reason for hospitalizations, and types of treatment you received.
Approximate Date Hospital Reason Treatment

____
____
____
____
____
____
____

8. Have you had any of the following tests performed? Please indicate date(s).

CT/MRI Scan ______
EEG ______
Spinal Tap ______

9. Please rate your overall health at the present time. **Circle One:** Poor Fair Good Excellent

10. Please indicate whether you (first box) or a member of your family (second box) has ever had any of the following illnesses:

Cancer/Tumor:	☐	☐
Diabetes:	☐	☐
High Blood Pressure:	☐	☐
Heart Disease:	☐	☐
Heart Attack/Angina:	☐	☐

Lung Disease:	☐	☐
Stroke:	☐	☐
Head Injury:	☐	☐
Other Loss of Consciousness:	☐	☐
Seizures/Epilepsy:	☐	☐
Learning Disability:	☐	☐
Attention Deficit/Hyperactivity	☐	☐
Multiple Sclerosis:	☐	☐
Parkinson’s Disease:	☐	☐
Huntington’s Disease:	☐	☐
“Senility”/Alzheimer’s Disease:	☐	☐
Psychiatric Illness:	☐	☐
Depression:	☐	☐
Other:	☐	☐

11. At any time, have you had a psychiatric, psychological, or neurological evaluation and/or treatment?
Name of Doctor: ______________________________________

Date   Institution   Location   Nature of Problem
____
____
____

12. Have you ever been to our office before or had a neuropsychological evaluation performed before?
if so, when?________ By whom?___________________________________

13. Do you smoke? _______ If so, how much? ___________________________

14. Do you drink alcohol currently? _____if so, how many drinks per week? ______________
Did you ever have a period of time that you drank alcohol to excess or had problems using non-prescription drugs? ______If so, when? ____

Have you ever received treatment for alcohol or chemical dependency? ___If so, when?_______

EDUCATIONAL AND OCCUPATIONAL HISTORY/CURRENT INTERESTS

1. How many years of formal education did you complete? ____________________________

2. Did you ever repeat any grades or need extra help in any school subjects? Receive special education services? ____

3. List activities (organizations, sports) in which you currently participate. Also, list hobbies/interests you currently pursue.____
____
____

4. Has your current illness or problems effected your ability to do your job? Your social life? If retired/unemployed, has it affected your ability to perform daily activities and chores? If so, please describe:
____
____

COMPENSATION/LITIGATION

1. Are you currently receiving disability compensation as a result of current or past illness? _____Yes _____ No If yes, please specify: ____

2. Are you currently involved in or planning a lawsuit or other legal action related to the illness for which you are being evaluated? _____Yes _____ No If yes, please specify: ____________________
____

CHECKLIST OF NEUROPSYCHOLOGICAL SYMPTOMS

Below is a list of questions about your health and health habits. Please think very carefully and check every problem that applies. If you are not sure what the question means or are not sure of your answer just draw a circle around the question and the doctor will help you with it later. Just be sure to answer every question.

Do you have...

1. __change in smell
2. __change in taste
3. __blurred vision
4. __double vision
5. __loss of vision
6. __blank spots in vision
7. __flashing lights in vision
8. __any paralysis
9. __muscle weakness
10. __muscle twitching
11. __muscle spasms
12. __trouble walking
13. __coordination problems
14. __balance problems
15. __tremors or shakiness
16. __problems with dropping things
17. __pain/headaches

Have you had...

18. __hearing loss
19. __ringing in the ears
20. __strange sounds in ears
21. __numbness
22. __tingling skin
23. __"pins and needles"
24. __burning skin
25. __loss of feeling
26. __loss of telling hot from cold
27. __change in skin
28. __black out spells
29. __seizures
30. __fainting spells
31. __periods where you lose time
32. __childhood diseases or injuries
33. __head injuries
34. __high fevers

Are you...
35. __blind in left eye
36. __blind in right eye
37. __blind in both eyes
38. __deaf in left ear
39. __deaf in right ear
40. __deaf in both ears

Do you...
41. __wear a hearing aid
42. __get lost often
43. __forget where you are
44. __forget time and day
45. __forget meetings
46. __forget names of people you know
47. __misplace or lose items
48. __repeat yourself
49. __have memory problems
50. __hear unusual sounds
51. __have strange feelings

Does it seem to you...
52. __can't think as quickly
53. __find it hard to think clearly
54. __are more easily distracted
55. __can't concentrate
56. __have trouble with common sense

Have you had trouble...
57. __using tools
58. __telling right from left
59. __getting dressed
60. __with numbers
61. __remembering right word when talking
62. __following conversations
63. __understanding what you read
64. __understanding others
65. __with your speech
66. __with reading
67. __with writing

Have you had problems with...
68. __sadness or depression
69. __worry or guilt
70. __stress or anxiety
71. __anger or keeping your temper
72. __change in your attitude
73. __loss of interest

Do you...
74. __work with chemicals
if so, which ones ________________________
____
____