



2919 Swann Avenue Suite 105A
 Tampa, FL 33609
 P: 813-353-9613

Medical History Questionnaire

Patient Name: _____ **Date:** _____
Address: _____ **Email:** _____
DOB: ___/___/___ **Age:** _____ **Height:** _____ **Weight:** _____
Referring Physician: _____

Patient Contact

Name: _____ **Relationship:** _____ **Phone:** _____
Email: _____ **Address (if different):** _____

Do you agree to receive text messages from Axiom Brain Health LLC? Yes / No

You may opt out of messages from Axiom Brain Health LLC at anytime Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.

Race:

- Asian Black Caucasian/White
 Native American Pacific Islander Other/ Prefer not to Answer

Ethnicity

- Hispanic or Latino Not Hispanic or Latino Other/ Prefer not to answer

Personal Medical History

List known drug allergies _____

Do you have a study partner who is available to attend appointments? _____

Have you had any of the following?

Problem		Date of Onset	Disorder		Date of Onset
High Blood Pressure	___ Yes ___ No		General		
Diabetes	___ Yes ___ No		Fatigue	___ Yes ___ No	
Heart Attack	___ Yes ___ No		Weight Loss	___ Yes ___ No	
Stroke	___ Yes ___ No		Fever	___ Yes ___ No	
TIA	___ Yes ___ No		Skin		
Seizures	___ Yes ___ No		Rash	___ Yes ___ No	
Kidney Failure	___ Yes ___ No		Skin Cancer	___ Yes ___ No	

Other	___ Yes ___ No		Head/Neck		
Respiratory			Headaches	___ Yes ___ No	
Cough	___ Yes ___ No		Head Injury	___ Yes ___ No	
Asthma	___ Yes ___ No		Neck Pain	___ Yes ___ No	
Shortness of Breath	___ Yes ___ No		Neck Injury	___ Yes ___ No	
Tuberculosis	___ Yes ___ No		Blurred Vision	___ Yes ___ No	
Pneumonia	___ Yes ___ No		Hearing Loss	___ Yes ___ No	
Cardiac			Ears Ringing	___ Yes ___ No	
Angina	___ Yes ___ No		Vertigo	___ Yes ___ No	
Irregular Heartbeat	___ Yes ___ No		Nose Bleeds	___ Yes ___ No	
Heart Murmur	___ Yes ___ No		Loss of Smell	___ Yes ___ No	
Heart Attack	___ Yes ___ No		Hoarseness	___ Yes ___ No	
Rheumatic Fever	___ Yes ___ No		Swallowing issues	___ Yes ___ No	
Renal/Urinary			Gastrointestinal		
Bladder Problems	___ Yes ___ No		Hepatitis	___ Yes ___ No	
Blood in Urine	___ Yes ___ No		Appetite Changes	___ Yes ___ No	
Behavioral			Nausea	___ Yes ___ No	
Substance Abuse	___ Yes ___ No		Vomiting	___ Yes ___ No	
STD	___ Yes ___ No		Blood in Stool	___ Yes ___ No	
Gynecological			Hematological		
Irregular Mens. Cycle	___ Yes ___ No		Transfusions	___ Yes ___ No	
Abnormal Bleeding	___ Yes ___ No		Anemia	___ Yes ___ No	
Contraceptive Use	___ Yes ___ No		Abnormal Bleeding	___ Yes ___ No	
Pregnancy	___ Yes ___ No		Cancer	___ Yes ___ No	



2919 Swann Avenue Suite 105A
 Tampa, FL 33609
 P: 813-353-9613

Endocrine			Emotional		
Diabetes	___ Yes ___ No		Anxiety	___ Yes ___ No	
Thyroid Problems	___ Yes ___ No		Depression	___ Yes ___ No	
Bone and Joints			Bipolar Disorder	___ Yes ___ No	
Pain	___ Yes ___ No		Psychosis	___ Yes ___ No	
Swelling	___ Yes ___ No		Insomnia	___ Yes ___ No	
Injury	___ Yes ___ No		Suicidal Thoughts	___ Yes ___ No	
Arthritis	___ Yes ___ No		Psych Treatment	___ Yes ___ No	

Please list all Surgical Procedures and Hospitalizations	
Procedure/Hospitalization	Date

Please list all current Medication	
	Start Date

Past Alzheimer's Workup			
Imaging	Date	Cognitive Testing	Result
MRI		MMSE	
FDG-PET		MoCA	
Amyloid-PET			
Blood Biomarkers	Result		
Amyloid	___pos___neg		
Tau	___pos___neg		
ApoE	___pos___neg		

Social History	
Marital Status	
Employment Status	
Do you have children?	
Have you ever smoked?	
Alcohol use	

Do you have a family history of the following?		
Problem		Relationship
Stroke	___Yes___No	
Heart Attack	___Yes___No	
Seizures	___Yes___No	
Dementia	___Yes___No	
Other		



2919 Swann Avenue Suite 105A
Tampa, FL 33609
P: 813-353-9613

Other		
-------	--	--

Vitals	
Blood Pressure	
Heart Rate	
Temperature	
O ₂ -Saturation	