Medical History Questionnaire

Date: _____

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

DOB: _____ **Age:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Do you live anywhere else part of the year?** _____ **Phone #:** _____ **Email:** _____

Sex/Gender: _____ **Height:** _____ **Weight:** _____ **Primary Care Provider:** _____ **Physician Phone:** _____ **How did you hear about us?**

_____

ALTERNATIVE CONTACT INFO

Name: _____ **Relationship:** _____

Phone #: _____ **Email:** _____

Can this person come to office visits with you? □ Yes □ No

GENERAL HISTORY

Do you have children? □ Yes □ No **Last menstrual cycle:** _____

Marital Status:

□ Married □ Divorced □ Separated

□ Single □ Widowed □ Domestic Partner

Employment Status:

□ Full Time □ Part Time / Contract

□ Self Employed □ Retired

Race:

□ White / Caucasian □ Black □ Asian

□ Native American □ Pacific Islander □ Other: _____

Ethnicity:

□ Hispanic / Latino □ Not Hispanic / Latino □ Prefer Not to Say

NEUROLOGICAL AND MEMORY QUESTIONS

How is your memory? (Check all that apply)

□ I have not noticed changes lately.

□ I have noticed mild changes lately.

□ Someone close to me has noticed changes lately.

□ I have been evaluated by a physician for memory.

Have you experienced any of the following? (Check all that apply) □ Difficulty walking / Shuffling □ Difficulty getting out of chairs □ Falls □ Slowness or stiffness of limbs □ Visual changes / Hallucinations □ Loss of smell

□ Change in handwriting □ Lightheadedness when standing □ Sleep changes / Insomnia □ Chronic constipation □ Tremors □ Speech changes

SOCIAL HISTORY

Alcohol Use:

□ Currently uses □ Previously used □ Never used

Smoking:

□ Currently uses □ Previously used □ Never used

Substance Use:

□ Currently uses □ Previously used □ Never used

YOUR MEDICAL HISTORY (Please check all current or past history)

□ High Blood Pressure □ High Cholesterol

□ Heart Attack: _____ □ Angina (chest pain) □ Heart Murmur

□ Stroke / TIA

□ Liver Disease

□ Depression / Bipolar □ Anxiety

□ Seizures

□ Parkinson's

□ Headaches / Injury □ Vertigo / Dizziness □ Insomnia

□ Diabetes: _____ □ Thyroid Issues

□ Asthma / COPD

□ Kidney Disease

□ Cancer: _____ □ Arthritis

□ Osteopenia / Osteoporosis

Family History?		Relationship
Dementia	____ Yes ____ No	
Alzheimer's	____ Yes ____ No	
Multiple Sclerosis	____ Yes ____ No	
Parkinson's	____ Yes ____ No	
Lewy Body Dementia	____ Yes ____ No	
Other	____ Yes ____ No	

Current Medications, Supplements, and Vitamins:

(Please list name, dose, frequency, reason for taking, and estimated date started)

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

Surgical Procedures or Hospitalizations:

Procedure / Reason _____ Date: _____

Procedure / Reason _____ Date: _____

Procedure / Reason _____ Date: _____

Procedure / Reason _____ Date: _____

Procedure / Reason _____ Date: _____

Procedure / Reason _____ Date: _____