# ADULT
# NEUROPSYCHOLOGICAL HISTORY QUESTIONNAIRE
# (ANHQ)

Patient's Name_____

Address (Street, City, ST, Zip)_____

Patient phone (H)_____ (W)_____

Guardian phone (H)_____ (W)_____

Age_____ Birth date_____ Sex_____ Education_____

Ethnic or Racial Background_____ Religion _____

Primary Language _____ Secondary Language_____

Hand used for writing: (check one) Right hand_____ Left Hand_____

Social Security Number _____ _____ _____

Job Title_____

School attending_____

Who do you live with?_____

Medical diagnosis: (1) _____

(2) _____

(3) _____

Who referred you for this evaluation?_____

Please rate problems/concerns in order of importance:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(6) _____

(7) _____

THIS FORM HAS BEEN COMPLETED BY: Patient____ Other____

If not completed by patient, please provide the following information:

Name_____ Relationship to patient_____

# SYMPTOM SURVEY

For each symptom that applies, place a check in the small box. Then, check if this is a NEW symptom (post injury or within the past year) or an OLD symptom (pre injury or over one year). Add any helpful comments next to the item.

## 1) PROBLEM SOLVING

| ✓ | New | Old | |
|---|---|---|---|
| ☐ | ___ | ___ | Difficulty figuring out how to do new things |
| ☐ | _____ | _____ | Difficulty planning ahead |
| ☐ | _____ | _____ | Difficulty thinking as quickly as needed |
| ☐ | _____ | _____ | Difficulty doing things in the right order (sequence problems) |
| ☐ | _____ | _____ | Difficulty changing a plan or activity when necessary |
| ☐ | _____ | _____ | Difficulty completing an activity in a reasonable amount of time |
| ☐ | _____ | _____ | Difficulty doing more than one thing at a time |
| ☐ | _____ | _____ | Difficulty switching form one activity to another activity |
| ☐ | _____ | _____ | Other:_____ |

## 2) SPEECH, LANGUAGE, AND MATH SKILLS

| ✓ | New | Old | |
|---|---|---|---|
| ☐ | ___ | ___ | Difficulty finding the right word to say |
| ☐ | _____ | _____ | Difficulty understanding what others are saying |
| ☐ | _____ | _____ | Unable to speak |
| ☐ | _____ | _____ | Difficulty staying with one idea |
| ☐ | _____ | _____ | Difficulty writing letters or words (not due to a motor problem) |
| ☐ | _____ | _____ | Slurred speech |
| ☐ | _____ | _____ | Odd or unusual speech sounds |
| ☐ | _____ | _____ | Difficulty with math (e.g., checkbook balancing, making change, etc.) |
| ☐ | _____ | _____ | Difficulty understanding what I read |
| ☐ | _____ | _____ | Difficulty spelling |
| ☐ | _____ | _____ | Other:_____ |

## 3) NONVERBAL SKILLS

| ✓ | New | Old | |
|---|---|---|---|
| ☐ | ___ | ___ | Difficulty telling right from left |
| ☐ | _____ | _____ | Difficulty doing things I should automatically be able to do (e.g., brushing teeth, etc.) |
| ☐ | _____ | _____ | Problems drawing or copying |

| ✓ | New | Old | |
|---|---|---|---|
| ☐ | _____ | _____ | Difficulty dressing (not due to physical difficulty) |
| ☐ | _____ | _____ | Difficulty writing letters or words (not due to a motor problem) |
| ☐ | _____ | _____ | Problems finding my way around places I have been to before |
| ☐ | _____ | _____ | Difficulty recognizing objects or people |
| ☐ | _____ | _____ | Parts of my body do not seem as if they belong to me |
| ☐ | _____ | _____ | Difficulty writing letters or words (not due to a motor problem) |
| ☐ | _____ | _____ | Unaware of things on one side of my body: Right side _____ Left side _____ |
| ☐ | _____ | _____ | Decline in my musical abilities |
| ☐ | _____ | _____ | Not aware of time (i.e., time of day, season, year) |
| ☐ | _____ | _____ | Slow reaction time |
| ☐ | _____ | _____ | Other:_____ |

## 4) CONCENTRATION AND AWARENESS

| ✓ | New | Old | |
|---|---|---|---|
| ☐ | _____ | _____ | Difficulty keeping my attention on a task or activity |
| ☐ | _____ | _____ | Highly distractible |
| ☐ | _____ | _____ | Lose my train of thought easily |
| ☐ | _____ | _____ | Problems concentrating for any length of time |
| ☐ | _____ | _____ | Difficulty writing letters or words (not due to a motor problem) |
| ☐ | _____ | _____ | Become easily confused or disoriented |
| ☐ | _____ | _____ | Blackout spells (fainting) |
| ☐ | _____ | _____ | My mind goes blank |
| ☐ | _____ | _____ | Aura (strange feelings) |
| ☐ | _____ | _____ | Don't feel very alert or aware of things |
| ☐ | _____ | _____ | Other:_____ |

## 5) MEMORY

| ✓ | New | Old | |
|---|---|---|---|
| ☐ | _____ | _____ | Forgetting where I leave things (e.g., keys, gloves, etc.) |
| ☐ | _____ | _____ | Forgetting names |
| ☐ | _____ | _____ | Forgetting what I should be doing |
| ☐ | _____ | _____ | Forgetting where I am or where I am going |
| ☐ | _____ | _____ | Forgetting events that happened quite recently (e.g., my last meal) |
| ☐ | _____ | _____ | Forgetting events that happened long ago (months or years) |

| ☐ | _____ | _____ | Need someone to give me a hint so I can remember things |
|---|---|---|---|
| ☐ | _____ | _____ | Relying more and more on notes to remember things |
| ☐ | _____ | _____ | Forgetting the order of things (e.g., when cooking, etc.) |
| ☐ | _____ | _____ | Forgetting facts, but I can remember how to do things |
| ☐ | _____ | _____ | Forgetting faces of people I know (when they are not present) |
| ☐ | _____ | _____ | Frequently forgetting appointments |
| ☐ | _____ | _____ | Other:_____ |

## 6) MOTOR AND COORDINATION

| ✓ | New | Old | | Check the side this occurs on: Right | Left | Both Sides |
|---|---|---|---|---|---|---|
| ☐ | _____ | _____ | Fine motor control problems (using a pencil, key, etc. | _____ | _____ | _____ |
| ☐ | _____ | _____ | Weakness on one side of my body | _____ | _____ | _____ |
| ☐ | _____ | _____ | Difficulty holding onto things | _____ | _____ | _____ |
| ☐ | _____ | _____ | Tremor or shakiness | _____ | _____ | _____ |
| ☐ | _____ | _____ | Muscle tics or strange movements | _____ | _____ | _____ |
| ☐ | _____ | _____ | My writing is very small | | | |
| ☐ | _____ | _____ | Walking more slowly than other people | | | |
| ☐ | _____ | _____ | Feeling stiff | | | |
| ☐ | _____ | _____ | Balance problems | | | |
| ☐ | _____ | _____ | Difficulty starting to move | | | |
| ☐ | _____ | _____ | Jerky muscles | | | |
| ☐ | _____ | _____ | Muscles tire quickly | | | |
| ☐ | _____ | _____ | Often bumping into things | | | |
| ☐ | _____ | _____ | Other:_____ | | | |

## 7) SENSORY

| ✓ | New | Old | | Check the side this occurs on: Right | Left | Both Sides |
|---|---|---|---|---|---|---|
| ☐ | _____ | _____ | Loss of feeling or numbness | _____ | _____ | _____ |
| ☐ | _____ | _____ | Tingling or strange skin sensations | _____ | _____ | _____ |
| ☐ | _____ | _____ | Difficulty telling hot from cold | _____ | _____ | _____ |
| ☐ | _____ | _____ | Problems seeing on one side | _____ | _____ | _____ |
| ☐ | _____ | _____ | Blurred vision | _____ | _____ | _____ |
| ☐ | _____ | _____ | Blank spots in vision | _____ | _____ | _____ |
| ☐ | _____ | _____ | Brief periods of blindness | _____ | _____ | _____ |

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ | _____ | _____ | See stars or flashes of light | _____ | _____ | _____ |
| ☐ | _____ | _____ | Double vision | | | |
| ☐ | _____ | _____ | Difficulty looking quickly from one object to another object | | | |
| ☐ | _____ | _____ | Need to squint or move closer to see clearly | | | |
| ☐ | _____ | _____ | Losing hearing | _____ | _____ | _____ |
| ☐ | _____ | _____ | Ringing in my ears or hearing strange sounds | | | |
| ☐ | _____ | _____ | Difficulty tasting food | | | |
| ☐ | _____ | _____ | Difficulty smelling | | | |
| ☐ | _____ | _____ | Smelling strange odors | | | |
| ☐ | _____ | _____ | Other:_____ | | | |

## 8) PHYSICAL

| ✓ | New | Old | |
|---|---|---|---|
| ☐ | ___ | ___ | Headaches Where:_____ Intensity:---------- Duration:_____ |
| ☐ | _____ | _____ | Dizziness |
| ☐ | _____ | _____ | Nausea or vomiting |
| ☐ | _____ | _____ | Urinary incontinence |
| ☐ | _____ | _____ | Loss of bowel control |
| ☐ | _____ | _____ | Excessive tiredness |
| ☐ | _____ | _____ | Pain Location: _____ |

Duration:_____

Intensity (0-None, 10-Worst its been) 1 2 3 4 5 6 7 8 9 10

How does it affect your emotions and activities:_____

_____

What helps the pain: _____

## 9) BEHAVIOR

| ✓ | Check all that apply to you in the past six months: | Rate how severe: Mild | Moderate | Severe |
|---|---|---|---|---|
| _____ | Sadness or depression | _____ | _____ | _____ |
| _____ | Anxiety or nervousness | _____ | _____ | _____ |
| _____ | Stress | _____ | _____ | _____ |
| _____ | Sleeping problems: (Falling asleep____ Staying asleep_____) | _____ | _____ | _____ |
| _____ | Become angry or irritable more easily | _____ | _____ | _____ |
| _____ | Euphoria (feeling on top of the world) | _____ | _____ | _____ |
| _____ | Much more emotional (e.g., cry more easily) | _____ | _____ | _____ |

| | | | | |
|---|---|---|---|---|
| _____ | Feel as if I just do not care anymore | _____ | _____ | _____ |
| _____ | Feel like hurting myself and/or another person | _____ | _____ | _____ |
| _____ | Less inhibited (do things I would not do before) | _____ | _____ | _____ |
| _____ | Hear voices or see things others do not hear or see | _____ | _____ | _____ |

_____ Change in eating habits:_____

_____ Change in interest in sex:_____

_____ Other recent change in behavior or personality:_____

10) Overall, my symptoms have developed: _____ Slowly _____ Quickly

11) My symptoms occur: _____ Occasionally _____ Often

12) Over the past 6 months my symptoms have:
_____ Stayed about the same
_____ Worsened
_____ Gotten better

## EARLY HISTORY

13) You were born On time _____ Prematurely _____ Late _____

14) Your weight at birth: _____ lbs. _____ oz.

15) Mother's weight gain during pregnancy: _____ lbs.

16) Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position, etc.) or the period immediately afterward (e.g., need for oxygen, special equipment used, convulsions, illness, etc.)

_____ Yes _____ No

If yes, describe:_____

17) Check all that applied to your mother while she was pregnant with you:

_____ Accident
_____ Alcohol use
_____ Cigarette smoking
_____ Drug use (marijuana, speed, cocaine, LSD, etc.)
_____ Poor nutrition
_____ Psychological problems
_____ Other problems: _____

18) List all the medications (prescribed or over-the-counter) your mother took while pregnant.

_____

19) During her pregnancy, did your mother live near a polluted area (e.g., toxic waste dump) or other hazardous area (nuclear plant, industrial area, pesticide sprayed area, etc.)? _____ Yes _____ No

If yes, describe:_____

20) Rate your developmental progress as it has been reported to you by checking one description for each area:

| | Early | Average | Late |
|---|---|---|---|
| Walking | _____ | _____ | _____ |
| Language development | _____ | _____ | _____ |
| Toilet training | _____ | _____ | _____ |
| Overall development | _____ | _____ | _____ |

21) As a child, did you have any of these conditions? (Check all that apply.)

_____ Attention problems
_____ Clumsiness
_____ Developmental delay
_____ Frequent ear infections
_____ Problems socializing
_____ Head injury
_____ Hearing problems
_____ Hyperactivity
_____ Learning disability
_____ Drug use
_____ Muscle tightness or weakness
_____ Speech problems
_____ Vision problems
_____ Psychological / behavior problems
_____ Involvement with police or juvenile Authorities

Other problems:_____

# MEDICAL HISTORY

## CHILDHOOD MEDICAL HISTORY

22) Check all the conditions that were diagnosed when you were a child. Add any helpful details (age at diagnosis, treatment provided, etc.)

_____ Allergies
_____ Asthma
_____ Brain infection or disease
_____ Cancer
_____ Cerebral palsy
_____ Chicken pox
_____ Colds (excessive)
_____ Diabetes
_____ Encephalitis
_____ Epilepsy or seizures
_____ Fevers (104 F or higher)
_____ Heart problems
_____ Immune system disease
_____ Kidney problems
_____ Lung (respiratory) disease
_____ Measles
_____ Meningitis
_____ Oxygen deprivation
_____ Pneumonia
_____ Poisoning
_____ Polio
_____ Rheumatic fever
_____ Scarlet fever
_____ Tuberculosis
_____ Venereal disease
_____ Whooping cough
_____ Psychological
_____ Other diseases or disabilities:_____
_____

23) As a child, were you exposed to excessive amounts of lead (e.g., eating paint chips, living next to high Concentration of automobile exhaust fumes, etc.)? _____ Yes _____ No
If yes, explain:_____

24) As a child, did you have an accident which required a hospital visit? _____ Yes _____ No
If yes, describe what happened:_____

25) Did you ever suffer a serious injury to your head? _____ Yes _____ No
If yes, explain the circumstances and any problems you had afterward: _____
_____
_____

26) How would you describe your nutrition as a child and adolescent?
Excellent _____ Average _____ Poor_____

27) List the medications that were regularly given to you as a child:

| | Medication | Reason for medication |
|---|---|---|
| a) | _____ | _____ |
| b) | _____ | _____ |
| c) | _____ | _____ |
| d) | _____ | _____ |

## ADULT MEDICAL HISTORY

28) Check all that currently apply:

| | | |
|---|---|---|
| _____ AIDS, ARC, or HIV+ | _____ Heart disease | _____ Parkinson disease |
| _____ Allergies | _____ Huntington disease | _____ Polio |
| _____ Arteriosclerosis (artery disease) | _____ Hypertension | _____ Psychiatric problems |
| _____ Arthritis | _____ Kidney disease | _____ Radiation exposure/ Therapy |
| _____ Blood disorder | _____ Liver disease | _____ Senility (Dementia) |
| _____ Brain disease/infection | _____ Lung disease | _____ Stoke or TIA |
| _____ Cancer or chemotherapy | _____ Malnutrition | _____ Thyroid disease |
| _____ Diabetes | _____ Meningitis | _____ Venereal disease |
| _____ Hazardous substance exposure | _____ Multiple sclerosis | _____ Arrest or incarceration |

_____ Any other problems:_____
_____

29) Have you ever been placed on disability? _____ Yes _____ No
If yes, please explain:_____

30) List any medication you currently take (over-the-counter or prescription medication) and the dosage.

| | Medication | Dosage | Usage |
|---|---|---|---|
| a) | _____ | | |
| b) | _____ | | |
| c) | _____ | | |
| d) | _____ | | |
| e) | _____ | | |

31) Do you have epilepsy or a seizure disorder? _____ Yes _____ No

If yes, check the one you have been diagnosed with:

| PARTIAL | GENERALIZED | _____ UNCLASSIFIED TYPE |
|---|---|---|
| _____ Simple partial (Jacksonian) | _____ Absence (Petit mal) | |
| _____ Complex partial (Psychomotor) | _____ Myoclonic | |
| _____ Partial evolving into generalized | _____ Clonic | |
| | _____ Tonic | |
| | _____ Tonio-clonic (Grand mal) | |
| | _____ Atonic | |

_____ I HAVE A SEIZURE DISORDER BUT DO NOT KNOW WHICH TYPE.

Please describe it:_____

32) Describe all of the hospitalizations you have had:

a) _____

b) _____

c) _____

d) _____

# FAMILY HISTORY

The following questions deal with your biological mother, father, brothers, and sisters.

## MOTHER

33) What is your mother's name? Include maiden name)_____

34) Is she alive? Yes_____ No_____ If deceased, what was the cause of death?_____

35) Mother's occupation: _____

36) Mother's level of education: _____

37) Mother's hobbies: _____

38) Does your mother have a known or suspected learning disability? Yes_____ No_____

If yes, describe: _____

39) Does your mother have a known or suspected psychological disorder? Yes_____ No_____

If yes, describe: _____

40) Briefly describe your mother's health history:_____

_____

## FATHER

41) What is your father's name?_____

42) Is he alive? Yes_____ No_____ If deceased, what was the cause of death?_____

43) Father's occupation: _____

44) Father's level of education: _____

45) Father's hobbies: _____

46) Does your father have a known or suspected learning disability? Yes_____ No_____
If yes, describe: _____

47) Does your father have a known or suspected psychological disorder? Yes_____ No_____
If yes, describe: _____

48) Briefly describe your father's health history:_____
_____

49 ) When you were born what was your mother's age? _____ Father's age_____

50) How many brothers and sisters do you have? _____
Names and ages: _____
_____

51) Where are you in the birth order? _____

52) Are there any problems (physical, academic or psychological) associated with any of your brothers or sisters?
Yes_____ No_____
If yes, describe:_____
_____
_____

53) Who raised you?
_____ Biological parent(s) _____ Relatives _____ Foster parents
_____ Biological parent plus other person _____ Adoptive parents
_____ Institutional setting _____ Other
Who? _____

54) What languages were spoken at home when you were a child?
1) _____ 2) _____
Primary language Secondary language

55) Please check all that exist(ed) in close biological (blood) family members (parents, brothers, sisters, grandparents, aunts, uncles). Note who it was and describe the problem where indicated.

| | Who? |
|---|---|
| _____ Epilepsy or seizures | _____ |
| _____ Learning disability | _____ |
| _____ Left-handedness | _____ |
| _____ Mental retardation | _____ |
| Neurological (brain) disease | |
| _____ Alzheimer's disease or senility | _____ |
| _____ Huntington disease | _____ |
| _____ Multiple sclerosis | _____ |
| _____ Parkinson disease | _____ |
| _____ Other neurological disease (describe) | _____ |

Psychiatric illness

_____ Alcoholism _____
_____ Bipolar illness (manic-depression) _____
_____ Depression _____
_____ Personality disorder _____
_____ Schizophrenia _____
_____ Other psychiatric illness (describe) _____

_____ Speech or language disorder _____
_____ Other major disease or disorder (describe) _____

# PERSONAL HISTORY

## MARITAL HISTORY

56) Current marital status: Married_____ Divorced_____ Widowed_____ Separated_____
57) Years married to current spouse: _____
58) Number of times married: _____
59) Spouse's name: _____ Spouse's age:_____
60) Spouse's occupation: _____
61) Spouse's education: _____
62) Spouse's health: Excellent_____ Good_____ Poor_____
If problems, please describe: _____
_____
63) Not married, but living with someone: Yes_____ No_____ His/her age:_____
His/her health: Excellent_____ Good_____ Poor_____
If problems, please describe:_____
_____
His/her occupation:_____
Partner's education:_____
64) Do you have any children: Yes_____ No_____ His/her ages:_____
65) Do your children have learning disabilities or other systemic diseases? Yes_____ No_____
If yes, please explain:_____
_____
_____

## EDUCATIONAL HISTORY

66) Highest grade or degree earned:_____

67) How would you describe your usual performance as a student in (please circle highest level):

High school College

| | Name of School | City/State | # Yrs Completed | Date Finished | Average | Grade Degree (A,B,C,D) | Diploma |
|---|---|---|---|---|---|---|---|
| Grades 1-6 | | | | | | | |
| 7-8/9 | | | | | | | |
| 9/10-12 | | | | | | | |
| University | | | | | | | |
| Post-graduate | | | | | | | |
| Other | | | | | | | |

Please provide any additional helpful comments about your academic performance: _____

_____

68) What was your best subject(s)? _____ Weakest subject(s)_____

69) Were you ever held back to repeat a grade? Yes_____ No_____

If yes, what grade(s):_____ Reason:_____

70) Were you ever in any special class(es) or received special services? Yes_____ No_____

If yes, what grade? _____ or age?_____ What type of class?_____

_____

**OCCUPATIONAL HISTORY**

71) Current job title:_____

72) Salary: Under $10,000_____ $10,000-$29,999_____ $30,000-$50,000_____ $50,000-$70,000_____

Over $70,000_____

73) How long have you been on this job? _____

74) Current job responsibilities:_____

_____

_____

| | (Start with most recent) | Reason for leaving | Time on this job |
|---|---|---|---|
| 75) Prior jobs: a) | | | |
| b) | | | |
| c) | | | |
| d) | | | |

76) At any time on a job, were you exposed to toxic, hazardous, noxious or otherwise dangerous or unusual substances (e.g., lead, mercury, radiation, solvents, pesticides, chemicals, etc)? Yes_____ No_____

**MILITARY HISTORY**

77) Branch:_____

78) Discharge rank: _____ Type of discharge:_____

79) Major military duties:_____

80) Did you sustain any physical injuries in the military? Yes_____ No_____

If yes, describe:_____

81) Were you ever exposed to any dangerous or unusual substances during your service (e.g., Agent Orange, radiation, etc? Yes_____ No_____

If yes, explain:_____

**RECREATION/SOCIALIZATION**

82) Briefly list the types of recreation activities (sports, games, TV, hobbies, etc.) you engaged in prior to your Injury or illness? _____

_____

_____

83) Briefly list the types of recreation activities that you presently engage in: _____

_____

_____

84) Briefly list typical social activities you engaged in (Church, clubs, service organizations, etc.) before your Injury or illness: _____

_____

_____

85) Briefly list typical social activities you engage in:_____

_____

_____

# SUBSTANCE USE HISTORY

**ALCOHOL**

86) I started drinking regularly at age:

Less than 10 years old _____ 10-15_____ 16-18_____ 19-21_____ over 21_____

87) I drink alcohol: rarely or never_____ 1-2 days/week_____ 3-5 days/week_____ Daily_____

I used to drink but have stopped_____ Date stopped_____

88) Preferred type(s) of drinks:_____

89) Usual number of drinks I have at a time: _____

90) My last drink was: Less than 24 hours ago_____ 24-48 hours ago_____ over 48 hours ago____

91) Check all that apply:

_____ I can drink more than most people my age and size before I get drunk.

_____ I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, accidents, etc.) after drinking

_____ I sometimes black out after drinking

**DRUGS**

92) Please check all the drugs you are now using or have used in the past:

| | **Presently using** | **Used in the past** |
|---|---|---|
| _____ Amphetamines (inc. diet pills) | _____ | _____ |
| _____ Barbiturates (downers, etc.) | _____ | _____ |
| _____ Cocaine or crack | _____ | _____ |
| _____ Hallucinogenics (LSD, acid, STP, etc.) | _____ | _____ |
| _____ Inhalants (glue, nitrous oxide, ect.) | _____ | _____ |
| _____ Marijuana | _____ | _____ |
| _____ Opiate narcotics (heroin, morphine, etc.) | _____ | _____ |
| _____ PCP (or angel dust) | _____ | _____ |

Please list all other drugs: _____

_____

(93) Do you consider yourself dependent on any above drug? Yes_____ No_____

Which one(s)? _____

_____

94) Do you consider yourself dependent on any prescription drug? Yes_____ No_____

Which one(s)?_____

_____

95) Check all that apply:

_____ I have gone through drug withdrawal

_____ I have used I.V. drugs _____ I have been in drug treatment

96) Have you ever been arrested for, or convicted of, any offense? Yes_____ No_____

If so, please explain:_____

_____

# MEDICAL

97) Identify the physician who is most familiar with your recent problems:

Name of physician:_____

Address:_____

_____

Phone: _____

Date of your last medical check-up:_____

Findings of the check-up:_____

_____

_____

98) Have you had a prior psychiatric, psychological or neuropsychological evaluation? Yes_____ No_____

If yes, complete this information:

Name of Doctor:_____

Address:_____

_____

Phone: _____

Date of and reason for this evaluation_____

_____

Findings of the evaluation:_____

_____

_____

99) Is there any other information that you believe would be relevant to this evaluation? _____

_____

_____

_____

_____

_____

_____

_____

100) What do you believe is your biggest problem? _____

_____

_____

_____

_____

_____

101) Are you presently involved in a lawsuit? Yes_____ No_____

If so, what?_____

_____

Attorney's Name: _____

Address:_____

Phone number:_____

How many lawsuits have you filed in your life? _____

102) Do you presently operate a vehicle? Yes_____ No_____

Do you have a current license? Yes_____ No_____ State:_____

License Number:_____ Type_____ Restrictions?_____

# HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

**SYMPTOMS** Check (✓) symptoms you currently have or have had in the past year.

### GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

### MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

### GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

### GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

### CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

### EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

### SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

### MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

### WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

**CONDITIONS** Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

**MEDICATIONS** List medications you are currently taking

**ALLERGIES** To medications or substances

Pharmacy Name_____ Phone_____

**(All information is strictly confidential)**

## FAMILY HISTORY Fill in health information about your family.

| Relation | Age | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |
| | | | | |

| Check (✓) if, your blood relatives had any of the following: Disease | Relationship to you |
|---|---|
| Arthritis, Gout | |
| Asthma, Hay Fever | |
| Cancer | |
| Chemical Dependency | |
| Diabetes | |
| Heart Disease, Strokes | |
| High Blood Pressure | |
| Kidney Disease | |
| Tuberculosis | |
| Other | |

## HOSPITALIZATIONS

| Year | Hospital | Reason for Hospitalization and Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## PREGNANCY HISTORY

| Year of Birth | Sex of Birth | Complications if any |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Have you ever had a blood transfusion?** ☐ Yes ☐ No

If yes, please give approximate dates._____

| SERIOUS ILLNESS/INJURIES | DATE | OUTCOME |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## HEALTH HABITS Check (✓) which substances you use and describe how much you use.

| | | |
|---|---|---|
| | Caffeine | |
| | Tobacco | |
| | Drugs | |
| | Other | |
| | | |
| | | |

## OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:

| | |
|---|---|
| | Stress |
| | Hazardous Substances |
| | Heavy Lifting |
| | Other |

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date