Neuropsychology
Assessment & Wellness
Dr. Beth Borosh

PATIENT HISTORY QUESTIONNAIRE
NEUROPSYCHOLOGY ASSESSMENT AND WELLNESS

Name: _____ Birthdate: _____ Today's Date: _____ Age: _____

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

What do you hope to learn from this assessment: _____

_____

_____

Describe any recent medical events that led up to this assessment: _____

_____

_____

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	_____	EEG	_____
Hospitalization	_____	Sleep Study	_____

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 judgment			
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 or hesitancy			
Difficulty emptying bladder			
Bowel or bladder accidents			
Urinary tract infections			
Numbness in arms and legs			
Weakness in arms or legs			
Trouble walking			
Gait imbalance			
Frequent falls			
Persistent dizziness			
Trouble sleeping			
Sleepiness			

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	_____		

❒ Exposure to Toxins (e.g., Mercury, Lead, Chlordane, Asbestos, Arsenic, etc.)

❒ 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	_____
With loss of consciousness? Y / N		❒ Movement disorder	_____	❒ Syphilis	_____

❒ Other (please describe): _____

PSYCHIATRIC

	Since?		Since?
❒ Alcohol Dependency	_____	❒ Depression	_____
❒ Anxiety Disorder	_____	❒ Manic-Depressive (Bipolar) Illness	_____
❒ Eating Disorder	_____	❒ Other (describe)	_____
❒ Drug Dependency	_____	_____	

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

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

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? (Please Circle)

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

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

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

*Describe any "YES" answers:_____

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

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 not working, when was your last job?_____ Why did you stop working?_____

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?_____

SOCIAL HISTORY (CONT):

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

Who is responsible for the following?	myself	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)
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.

1. Name: _____

   Address: _____

   City/State/Zip: _____

   Phone: _____

   Fax: _____

2. Name: _____

   Address: _____

   City/State/Zip: _____

   Phone: _____

   Fax: _____

Date of Visit: _____ **Patient Name:_____**

How did you hear about Dr. Borosh?

___ Friend or Family Member

___ Word of Mouth, Reputation

___ Internet

___ My Doctor referred me

___ Other Source (specify) _____

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