MEMORY CENTER HISTORY FORM

Date of First Appointment: _____
Birthplace: _____ Sex: _____F _____M Age: ____
Name: _____ Birthdate: _____
Address: _____ City: _____ State: _____
Telephone: Home:_____
Work: _____
Cell: _____
Number of years of Education: _____
Primary Occupation throughout life: _____
Referred by: (check one)
____self ____Family ____Friend ____Primary Doctor ____Specialist

Name, address and phone number of doctor making referral: _____
_____

Name, address and phone number of primary care physician: _____
_____

Has the patient been evaluated previously for memory problems and if so by whom? _____
_____

How long ago did the patient begin to show signs of memory problems? _____

Did the memory problems develop:

Gradually/Insidiously ____

Suddenly _____

Unclear _____

Circle all of the symptoms that were first noted and describe:

Memory problems.....

Language problems.....

Behavior/personality changes .....

Intellectual/comprehension changes.....

Visual Spatial/Perceptual changes .....

Depression .....

Hallucinations/ paranoia/ agitation/aggression .....

Motor function changes (weakness, gait changes) .....

Repeats same questions/stories over and over .....

Misplaces personal items frequently .....

Have the changes noted above progressed? _____

Describe the changes in the patient that you have noted since the onset of memory problems:

Does the patient have problems sleeping ? If yes, describe:

Does the patient have aggressive, agitated, or other difficult behaviors? Is yes, describe:

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PAST MEDICAL HISTORY

Do you have or have you had: *(check if "yes" or if none apply check here _____)*

High Blood Pressure_____ Diabetes_____ Stroke_____ Headaches_____

Epilepsy or Seizures_____ Depression or Psychiatric Disease _____

Arthritis_____ Thyroid_____ Heart Problems_____ Cancer_____

Kidney Disease_____ How much alcohol do you drink each week?_____

How many cigarettes do you smoke a day?_____ Do you take birth control pills?_____

Other Significant Illnesses: (please list): _____

_____

Parevious Operations (list type and year):_____

Any serious injuries? _____No _____Yes Describe_____

FAMILY HISTORY:

	If Living Age	Medical Problems	If Deceased Age at Death	Cause of Death
Father:				
Mother:				

	Number	Ages	Medical Problems	Number Deceased	Age at / Cause of Death
Brothers:					
Sisters:					
Children:					

Do you know of any blood relative who has or had: *(check and give relationship or if none check here_____):*

Alzheimer's_____Parkinson's_____Stroke_____ Seizures_____

Multiple Sclerosis_____ Depression or Psychiatric Disease _____

Learning Disability_____ Lupus_____ Diabetes_____

Heart Disease_____ Cancer_____ Mental Retardation /Down Syndrome

OCCUPATION:_____

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SYSTEMS REVIEW

As you review the following list, please check any of those problems which you may be expressing or have experienced. If you do not have any of the problems listed in a section, please check none.

GENERAL:
_____ Recent weight gain
_____ Recent weight loss
_____ Fatigue
_____ Fever
_____ Bleeding, low blood
_____ Night sweats
_____ None

EYES:
_____ Pain
_____ Loss of vision
_____ Double or blurred vision
_____ Dryness
_____ None

EARS, NOSE, MOUTH, THROAT:
_____ Ringing in ears
_____ Loss of hearing
_____ Loss of smell
_____ Sinus infection
_____ Sores in mouth
_____ Loss of taste
_____ Dryness
_____ Hoarseness
_____ Difficulty in swallowing
_____ None

KIDNEY/URINE/BLADDER:
_____ Urinary tract infections
_____ Urgency
_____ Incontinence
_____ Retention
_____ Discharge from penis/vagina
_____ Rash/ulcers
_____ Prostate trouble
_____ None

PHYSICIAN COMMENTS:

LYMPHATIC:
_____ Swollen glands
_____ Tender glands
_____ None

HEART AND LUNGS:
_____ Pain in chest
_____ Irregular heart beat
_____ Shortness of breath
_____ Difficulty in breathing at night
_____ Swollen legs or feet
_____ Blood clots in legs
_____ High blood pressure
_____ Heat murmurs
_____ Cough
_____ Coughing of blood
_____ Wheezing
_____ None

STOMACH AND INTESTINES:
_____ Nausea/Vomiting
_____ Stomach pain
_____ Yellow jaundice
_____ Increasing constipation
_____ Persistent diarrhea
_____ Blood in stools
_____ Heartburn
_____ None

SLEEP ABNORMALITIES:
_____ Daytime Sleepiness
_____ Snoring
_____ None

SKIN:
_____ Easy bruising
_____ Rash
_____ Hives
_____ Sun sensitivity
_____ Tightness
_____ Nodules/bumps
_____ Hair loss
_____ Color changes of hands or feet in the cold
_____ None

MUSCLES/JOINTS/BONES
_____ Morning stiffness
_____ Joint pain/swelling
_____ Muscle tenderness
_____ Other _____
_____ None

ENDOCRINE:
_____ Thyroid problems
_____ Other _____
_____ None

MOOD:
_____ Depression
_____ Anxiety
_____ None