Family Report: The Medical History Instructions

(Do not copy this page for patients or family)

This tool is one in a series of questionnaires designed to collect information generally relevant to the differential diagnosis of a memory problem.

"Family Report: Medical History" collects information about the patient — pertinent negatives, education and employment history, medication, health habits and a review of systems specific to memory disorder differential diagnosis. This questionnaire may be completed by the patient, the family, or both together. Some sections collect information about current and remote health problems, and these may be omitted for established patients.

Family Report: The Medical History

Instructions To determine the cause of memory problems, the doctor needs details about the person's history, including current and past medical problems, medications, health habits, and family history. The information may need to be gathered from both the person and family members.

The name of the person is: _____

My name is: _____

My telephone is: _____

Past Medical History

Has the person been affected by any of the following medical conditions? If so, when was it first found?

No	Yes	When?	Condition
☐	☐	_____	High blood pressure
☐	☐	_____	Heart disease, angina
☐	☐	_____	Thyroid trouble
☐	☐	_____	High cholesterol
☐	☐	_____	Stroke
☐	☐	_____	Neuropathy
☐	☐	_____	Poor circulation
☐	☐	_____	Diabetes
☐	☐	_____	Hepatitis
☐	☐	_____	Serious head injury
☐	☐	_____	Parkinson's disease
☐	☐	_____	Drinking problem
☐	☐	_____	Depression
☐	☐	_____	Syphilis or other venereal disease
☐	☐	_____	Seizures
☐	☐	_____	Street drug use
☐	☐	_____	Cancer
☐	☐	_____	Brain hemorrhage or hematoma
☐	☐	_____	Meningitis or encephalitis
☐	☐	_____	Severe vision or hearing loss
☐	☐	_____	Vitamin deficiency
☐	☐	_____	Brain CT scan or MRI

Current Medical History

Please list the medical conditions currently affecting the person or that they are currently receiving treatment.

When did it begin?	Condition
[redacted]	[redacted]

Former Medical Problems

Please list all the medical conditions the person has had in the past however no longer cause problems.

When did it begin?	Condition

Surgical History

Please list all operations the person has had, with the approximate date.

Date	Operation

Psychiatric History

Please list all mental health or psychiatric conditions or treatments the person has had, with the approximate date of onset for each.

Date	Condition or Treatment

Education and Employment

What is the highest level of formal education the person completed? _____

What was the primary type of work the person performed?

_____

What other jobs has the person held? _____

_____

Has the person ever worked with chemicals, solvents, or heavy metals (for example, lead)?_____No_____Yes
If yes, which ones?_____

Does the person have any history of exposure to radiation or radiation therapy? _____No_____Yes

Has the person ever had electroconvulsive (ECT) or "shock" therapy?_____No____Yes

Has the person ever been a boxer?_____No_____Yes

Prior Evaluation

Have you had brain imaging study (CT brain or MRI)?

_____No _____Yes

If yes, where and when? _____

_____

Have you had blood tests for memory loss?

_____No _____Yes

If yes, where and when? _____

_____

Have you had an evaluation for memory loss before?

_____No _____Yes

If yes, where and when? _____

_____

Family History

Please indicate which family members have had any of the following medical conditions (give the relationship to the person, not the relative's name):

Condition	**Family Member(s)**
Alzheimer's disease or dementia	_____
Parkinson's disease	_____
Depression	_____
Stroke	_____
Heart Disease	_____
Down syndrome	_____
Diabetes	_____

Health Habits

If the person ever smoked, how many packs per day and for how many years? _____

If the person no longer smokes, when did he or she quit?

_____

Does the person drink any alcoholic beverages on most days?

_____No_____Yes

If yes, how many drinks per day, usually? (1 drink is 1 beer, 6 oz of wine, or 2 oz of hard liquor) _____

Is the person currently driving? _____

Medication History

Please list all **prescription** medicines that the person is currently taking.

Name of medication	**Strength and times per day**

Please list all **over-the-counter** medicines that the person is currently taking at least once a week.

Name of medication	**Strength and times per day**

Review of Systems

Has the person experienced any of the following problems in the past few years? Please describe any problems briefly, with approximate dates. If you need more room, write on the back of the sheet. Leave the blank empty if the problem had not occurred.

Problem	**Description, date(s)**
Change in personality	
Trouble talking, finding words	
Weakness on one side	
Poor judgment	
Episodes of severe confusion	
Loss of alertness, inability to wake up	
Believing something that is obviously not true	
Cries, gets angry without reason	
Vision or hearing loss	
Problem with teeth, gums	
Injury from a fall	
Trouble with balancing, walking	
Snoring loudly, gasping for breath while sleeping	
Shortness of breath	
Chronic coughing	
Change in bowel habits	
Bleeding from the rectum	

Review of symptoms, continued

Problem	**Description, date(s)**
Increased or decreased interest in sex	
Trouble with urination, incontinence	
Pain in joints or bones	
Limited movement of arms, legs	
Bleeding or enlarged spots on skin	
Unusual skin dryness or sweating	
Changes in appetite	
Unusual thirst	
Extreme fatigue	
Change in sleep habits	
Weight loss or gain	
Inability to prepare or eat food	

When you have completed this form, please return it to: _____

_____