

Health Questionnaire

Name: _____ Date: _____

Please give us as much information as you can about your prior medical history. If possible, give dates, medication doses, names and phone numbers of treating doctors.

How would you characterize your health, in general, in the past:

Excellent Good Average Poor Awful

How would you characterize your health, right now:

Excellent Good Average Poor Awful

Do you have any allergies (drugs, food allergies, seasonal allergies)?

Do you have any serious or chronic medical conditions?

Have you had any serious medical conditions in the past?

Have you been hospitalized, or had any operations or surgical procedures?

List the medicines you are taking right now:

List the medicines you have taken in the past:

Please list your family physician and your other recent doctors:

Which doctor(s) should receive a copy of our report?

Past or present use of:

Tobacco: _____

Alcohol: _____

Drugs: _____

Please indicate if you have any of these problems:

- Skin conditions
- Frequent Headaches
- Migraines
- Past head injury
- Loss of consciousness
- Dizziness/Vertigo
- Glasses/contact lenses
- Blurry vision
- Double vision
- Cataracts
- Glaucoma
- Hearing loss
- Ringing in the ears
- Nose bleeds
- Frequent sinusitis
- Seasonal allergies
- Sore throat
- Respiratory problems
- Shortness of breath
- Asthma
- Frequent cough
- Chest pain
- Cardiac problems
- Heart murmur
- Heart attack
- High cholesterol
- High blood pressure
- Abdominal pain
- Heartburn/reflux
- Ulcers
- Nausea/vomiting
- Diarrhea/constipation
- Gallstones
- Liver problems
- Hernias
- Frequent urinary infections
- Frequent urination
- Incontinence
- Kidney stones
- Gynecological problems
- Menopause/Hormone Replacement Therapy
- Muscle weakness
- Joint pain
- Back pain
- Arthritis
- Memory loss
- Stroke
- Seizures
- Poor coordination
- Motor tics
- Numbness/Tingling
- Hyperthyroid
- Hypothyroid
- Diabetes mellitus
- Heat/cold intolerance
- Weight gain/loss
- Changes to hair
- Fatigue
- Anemia
- Bruise easily
- Past blood transfusions
- Blood disorder
- Other:

What are your most troublesome problems at this time?

Please indicate if any biologically related family member suffers from any of these medical problems:

- | | |
|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cardiac problems | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Multiple Sclerosis |

Please indicate if any biologically related family member suffers from any of these neuropsychiatric problems:

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Psychiatric hospitalization |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anger problems |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Obsessive Compulsive disorder | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Autism/Asperger's |
| <input type="checkbox"/> Psychosis or hallucinations | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Tourette's syndrome | |
| <input type="checkbox"/> Learning Disability | |

Other important family information that we ought to know:

Thanks for giving us this information. It will be treated with the utmost discretion. We do, however, routinely communicate relevant information with other treating health professionals and with family members, when appropriate.

You are encouraged to bring your spouse with you.

It is a privilege for us to serve you at NC Neuropsych, and we appreciate your confidence. Our website is www.ncneuropsych.com. Our numbers are: 919.933.2000 (Chapel Hill) and 704.529.4101 (Charlotte).

E-mail is not a reliable way to communicate with us. Voice mail is very reliable, though. If you need to get through to an operator, you can press "zero." After hours, and on weekends, our numbers are on the answering machine. Please let us know if you ever have trouble getting through.

Sometimes it is hard to get a follow-up appointment. If you have to be seen sooner, ask for an emergency appointment. We try very hard to accommodate urgent situations.