SARASOTA MEMORIAL HEALTH CARE SYSTEM

Memory Disorder Clinic Health History Questionnaire

Name _____ **Date of Birth** _____

Personal Medical History	
Check if you have had any of the following	
☐ Sleep Apnea	☐ Syphilis
☐ Peripheral Vascular Disease	☐ Sexually Transmitted Disease
☐ Hepatitis	☐ Substance Abuse
☐ Head Injury	☐ Brain Hemorrhage
☐ Parkinson's Disease	☐ Meningitis
☐ Alcohol Disorders	☐ Encephalitis
☐ Unconsciousness	☐ Vitamin Deficiency
☐ Learning Disability	☐ Other
Mental Health History	
Check if you have had any of the following	
☐ Acute Stress Disorder	☐ Emotional Mood Disorder
☐ Panic Disorder	☐ Schizophrenia
Current Health Concerns	
Please check problems or conditions that you are CURRENTLY experiencing	
☐ Change In Personality	☐ Numbness
☐ Difficulty Finding Desired Words	☐ Difficulty Breathing
☐ Poor Judgement	☐ Chronic Cough
☐ Periods of Confusion	☐ Change In Bowel Habit
☐ Difficult to Rouse	☐ Loss of Urinary Control, Incontinence
☐ Believing Something Obviously Untrue (Delusions)	☐ Frequent Urination
☐ Seeing Things That Are Not There (Hallucinations)	☐ Change In Sexual Interest, Increased
☐ Crying For No Reason	☐ Change In Sexual Interest, Decreased
☐ Feeling Angry	☐ Joint Stiffness
☐ Worsening Vision	☐ Joint Pain
☐ Loss of Hearing	☐ Limited Range of Motion In Arms or Legs
☐ Teeth Symptoms	☐ Easy Bruising or Bleeding
☐ Gum Symptoms	☐ Excessively Dry Skin
☐ Fall With Injury	☐ Excessive Sweating
☐ Difficulty With Balance	☐ Changes In Appetite
☐ Difficulty With Walking, Unsteady	☐ Increased Thirst
☐ Muscle Weakness	☐ Fatigue
☐ Left Side	☐ Snoring Loudly
☐ Right Side	☐ Awakening At Night Short of Breath
☐ Lower Limbs	☐ Disturbances In Sleep
☐ Upper Limbs	☐ Fainting
Previous Testing	
☐ X-Ray	☐ MRI
☐ CT Scan	☐ Other

Family History				
	Mother	Father	Brother	Sister
☐ Down's Syndrome				
☐ Parkinson's Syndrome				
☐ Other				

Education and Employment
Highest Level of Education Achieved: ( ) Years Completed
Previous Occupation:
Work History:

Occupational Environmental Exposures	
Check if you have had any of the following	
☐ Exposure To Chemicals	☐ Exposure To Mercury
☐ Exposure To Metals	☐ Exposure To Nickel
☐ Exposure To Aluminum	☐ Exposure To Platinum
☐ Exposure To Arsenic	☐ Exposure To Silver
☐ Exposure To Chromium	☐ Exposure To Tin
☐ Exposure To Lead	☐ Exposure To Uranium
☐ Exposure To Magnesium	☐ Exposure To Zinc

Other Exposures
Check if you have had any of the following
☐ History of Electroconvulsive Therapy (ECT)
☐ History of Radiation Therapy
☐ History of Sports Related Trauma or Injury

Safety Assessment
Please check all that apply
Are you still driving? ☐ Yes ☐ No
If Yes, have there been any motor vehicle accidents within the last 3 years? ☐ Yes ☐ No
If Yes, have there been any tickets or driving restrictions within the last 3 years? ☐ Yes ☐ No
Are you taking medications as prescribed? ☐ Yes ☐ No
Have you gotten lost in familiar places? ☐ Yes ☐ No
Are there weapons/guns in the home? ☐ Yes ☐ No
Are there concerns about safety in the home? ☐ Yes ☐ No
Have you had multiple sexual partners? ☐ Yes ☐ No
Have you had same sex partner(s)? ☐ Yes ☐ No
Do you (the patient) feel safe at home? ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____