ROCKY MOUNTAIN
Memory Center
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Rocky Mountain Memory Center

PATIENT HISTORY

Demographic Information

What is going on in your life that leads you to believe that you have attentional problems or memory defects?

_____

_____

What do you normally do to compensate for these problems?

_____

_____

Severity Level: Mild Moderate Severe

Onset Date: _____

Progression: Rapid Gradual

Frequency of Episodes: Daily Weekly Infrequent
Other: _____

Dominant Hand: Right Left

Medical:
Eye glasses: Yes No
Hearing loss: Yes No
Hearing aids: Yes No
Walks: Independently cane walker

Head Neuroimaging: Have you ever had a head CT scan or Brain MRI?: Yes No
If yes: Date: _____ Location:_____

Neurological Consult: Have you ever seen a neurologist? YesNo
If Yes: Date: _____ Neurologist: _____
Reason: _____

Head Injury: Have you ever had a head injury? Yes No
Are you currently in the process of litigation resulting from your head injury? Yes No
If yes, please describe: _____
_____
_____

Educational Information

What is the highest level of education: _____

Did you attend or are you attending any post-high school education (e.g., college or technical school)?

Y **N**

School	Dates	Major	GPA	Graduated?	Degree Obtained
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Occupational Information

What jobs have you had since high school

Job	Dates	Job Duties	Why/how ended?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Where were you born? _____

Have you ever been married? **Y** **N**

If yes, to whom?

Partner's Name	Dates	Why/how ended?
_____	_____	_____
_____	_____	_____

List names of children

Name	Location	Current Age

Health History

Are you currently in good health **Y** **N**

What was the date of your last physical? _____

Do you have any major, chronic health conditions? **Y** **N**

(If you answered yes, please list them.)

1. _____
2. _____
3. _____
4. _____

As an adult, have any of the following happened to you? If so, what was the outcome?

Hospitalized (other than childbirth) **Y** **N** _____

Sexual, physical, or emotional abuse? **Y** **N** _____

Head injuries/loss of consciousness **Y** **N** _____

Chronic Pain **Y** **N** _____

Hyper/hypothyroidism/thyroid problems **Y** **N** _____

Sleep Problems / Sleep Apnea	**Y**	**N**	_____
Seizures/Epilepsy	**Y**	**N**	_____
Neurological Disease, Parkinsons, MS, etc.	**Y**	**N**	_____
Menopause/hormonal imbalance	**Y**	**N**	_____
Sensory deficits like hearing loss	**Y**	**N**	_____
Heart Disease	**Y**	**N**	_____
High blood pressure	**Y**	**N**	_____
Diabetes	**Y**	**N**	_____
Migraines	**Y**	**N**	_____
Respiratory Problems	**Y**	**N**	_____
Neuromotor Problems	**Y**	**N**	_____

Are you currently taking any medications for **medical conditions**? **Y** **N**

	Medication 1	**Medication 2**	**Medication 3**
Drug Name	_____	_____	_____
For what problem	_____	_____	_____
Dose	_____	_____	_____
	Medication 4	**Medication 5**	**Medication 6**
Drug Name	_____	_____	_____
For what problem	_____	_____	_____
Dose	_____	_____	_____

Adult Psychological/Psychiatric History

As an adult, have you seen a counselor, psychologist, or psychiatrist for any reason?
Y N

	Provider 1	Provider 2	Provider 3
For what problems?			
What kind of professional?			
Professional's name			
Age started			
Age stopped			
How often?			
Reason for stopping			

As an adult, have you taken any **psychiatric medications**?

	Medication 1	Medication 2	Medication 3
Drug name			
Prescribed by			
Age started			
Age stopped			
For what problems?			
Total daily dose			
Benefits			
Side effects			

Lifestyle

Lifestyle: Height: _____. Weight: _____.

Dietary/Nutritional Habits: _____.

Physical activity level:

- Type of exercise: _____
- Frequency: _____

Social/mental stimulation:

- Activities, groups, clubs: _____

Engage in regular religious, spiritual or meditation practice: _____.

Do you, or did you, use any of the following substances?

Substance	Use	Age of first use	Age of last use	Age of heaviest use	Heaviest usage (amount per day)	Current usage (amount per day)
Alcohol	Y N					
Cigarettes	Y N					
Coffee/tea/coke /soda	Y N					

Sleep

Trouble getting or staying asleep **Y N**

Light sleeper, trouble staying sleep or easily awakened **Y N**

Snoring **Y N**

Talks or walks in sleep **Y N**

Restless legs **Y N**

Feels foggy headed or tired upon awakening **Y N**

Mood

Have you ever, as an adult, had a period of time when you were:

Feeling depressed or sad more often than not, or found that you could not enjoy things you used to enjoy? **Y N**

Feeling a lot of anxiety or tension or worry all the time about things – more so than other people? **Y N**

Do those close to you complain that you have a hot temper or a short fuse? **Y N**
Do you have rapid, brief moods swings? **Y N**
Are there any major stressors occurring in your life right now? **Y N**

If you answered yes to the previous question, please list the stressors:

1. _____
2. _____
3. _____