ROCKY MOUNTAIN
Memory Center
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Rocky Mountain Memory Center

PATIENT HISTORY

Clinical History

What issues brings you in for evaluation (Please circle all that apply):

Inattention; Memory loss; Neurological Disorder; Neuromotor (falls, imbalance, ect.), Chronic Pain; Insomnia; Mood Disorder (eg. Anxiety, Depression); Other

Describe Briefly

_____

_____

_____

_____

Onset Date: _____

Severity Level: Mild Moderate Severe

Progression: Rapid Gradual

Frequency of Episodes: Daily Weekly Infrequent

COGNITION

Amnestic type memory loss or forgetting what was said after very brief time: Yes; No
Explain: _____

Inability to recall conversations, appointments or details at the end of the day or next day: Yes; No

Explain: _____

Easily distracted, unable to complete thoughts: Yes; No
Explain: _____

Tends to repeat self or ask the same question over and over: Yes; No
Explain: _____

History of prior diagnosis or problem with attention or learning disorder: Yes; No
Explain: _____

Fluctuations in cognition or alertness from day to day or throughout day: Yes; No
Explain: _____

Episodes of confusion or disorientation: Yes; No
Explain: _____

Inability to work TV remote, front door keys, fender benders, easily getting lost: Yes; No
Explain: _____

Problems with word recall or names: Yes; No
Explain: _____

Getting lost while driving: Yes; No
Explain: _____

Inability to follow instructions: Yes; No
Explain: _____

NEUROLOLOGICAL

Neurological Consult: Have you ever seen a neurologist? Yes No
If Yes: Date: _____ Neurologist: _____
Reason: _____

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

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

Diagnosis of MS: Yes; No: _____

Diagnosis of Parkinson's disease: Yes; No: _____

Imbalance: Yes; No _____

Falls: Yes; No _____

Chronic fatigue: Yes; No _____

Impaired alertness/arousal level: Yes; No _____

General weakness: Yes; No _____

Loss of consciousness: Yes; No _____

Tremor: Yes; No _____

Trouble swallowing: Yes; No _____

Extreme motor slowing: Yes; No _____

Seizures/Epilepsy: Yes; No _____

SLEEP DISORDER

Trouble getting to sleep: Yes: No _____

Light sleeper, trouble staying sleep or easily awakened: Yes; No _____

Snoring: Yes; No
If so, how loud is your snoring? Not as loud as talking / Louder than talking
How often do you snore? Nearly every day / 3-4x a week / 1-2x a week

Have you ever noticed that you quit breathing during your sleep? Yes; No
If so, how often do you notice? Nearly every day / 3-4x a week / 1-2 x a week

Talks or walks in sleep: Yes; No _____

Vivid dreams/ acts out dreams; Yes; No _____

Restless legs; Yes; No_____

Feels foggy headed or tired upon awakening: Yes; No _____

Do you have trouble staying awake during the day: Yes; No _____

Do you take naps: Yes; No _____

On a scale of 1-10 how tired are you during the day: _____

Have you been diagnosed with sleep apnea; Yes; No: _____
Sleep study: Where: _____ Year: _____

Do you wear a CPAP/BiPAP: Yes; No _____

CHRONC PAIN

Chronic Pain Disorder: Yes; No Type: _____

Fibromyalgia: Yes; No _____

Migraines: Yes; No _____

Frequency: _____ Severity: _____

Peripheral Neuropathy: Yes; No _____

Cervical/Back pain: Yes; No _____

NEUROBEHAVIORAL

Acute change in mood: Yes; No _____

Suspiciousness/ Paranoia: Yes; No _____

Reactive Anxiety/ Agitation: Yes; No _____

Auditory or Visual Hallucinations: Yes; No _____

Systematized delusions: Yes; No _____

Abulia/ Lack of spontaneity / inertia/ lack of get up and go: Yes; No _____

GENERAL HEALTH

Do you have any major, chronic health conditions? Y N
(If you answered yes, please list them.)

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

Eye glasses: Yes: No _____

Hearing loss: Yes: No _____ Hearing aids: Yes No _____

Walks: Independently cane walker

Dominant Hand: Right Left

High Cholesterol: Yes; No: _____

Hypertension: Yes; No: _____

Diabetes/Prediabetes : Yes; No: _____

Respiratory Disease: Yes; No: _____
Daytime Oxygen: Yes; No: _____

Heart Disease / Heart attack: Yes; No: _____

TIA/Stroke: Yes; No: Year: _____

Dizziness: Yes; No: _____

Vertigo/vestibular problem: Yes; No: _____

Orthostatic hypotension: Yes; No: _____

Syncope/unexplained falls: Yes; No: _____

Incontinence: Yes; No: _____

Constipation: Yes; No: _____

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	_____	_____	_____

Educational /Occupational 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)? YES No

School	Dates	Major	GPA	Graduated?	Degree Obtained

What were your most recent jobs?

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

Adult Psychological/Psychiatric History

History of sexual, physical or emotional abuse? _____

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? Yes; No

Feeling a lot of anxiety or tension or worry all the time about things – more so than other people? Yes; No

Do those close to you complain that you have a hot temper or a short fuse? Yes: No

Do you have rapid, brief moods swings? Yes; No

Are there any major stressors occurring in your life right now? Yes; No

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

1. _____
2. _____
3. _____

As an adult, have you seen a counselor, psychologist, or psychiatrist for any reason? Yes; No

_____

_____

_____

_____

Lifestyle

Lifestyle: Height: _____. Weight: _____.

Dietary/Nutritional Habits: _____

Physical activity level:

- Type of exercise: _____
- Frequency: _____

Social

- Activities, groups, clubs: _____

Mental stimulation: _____

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					