Please complete this questionnaire at home and bring it with you to the office of Dr. John Largen & Associates at the time of your appointment. This form can be completed by yourself (the patient) or by another family member. Questions? Call 281-957-9863

WHO IS COMPLETING THIS FORM? Patient Other (*specify relationship*):

PERSONAL AND SOCIAL HISTORY:

Patient's Full Name: Name of Referring Doctor:

Date of Birth: Age: Sex: M F Race: Left or Right Handed (Circle)

Are you bilingual? Yes No If yes, what is your preferred language?

Are you **currently** (circle): Single Married Divorced Widowed Committed Relationship

If married: What is your spouse's name?:

How long have you been married?:

How is your spouse's health? (please circle): Excellent Fair Poor

Does your spouse work outside of the home? (circle) Yes No

How many times have you been married? **How long** was each marriage?

Please list **those who are living with you**:

Name Relationship to you:

1.)
2.)
3.)
4.)

Please list the names and ages of any children not living with you:

At your home, who is **primarily** responsible for these activities?

Cooking Shopping
Cleaning Paying the Bills
Driving

PROBLEMS AND SYMPTOMS:

-What is your understanding of why you have been referred for testing?

-**What types of problems** are causing you difficulty at this time?

-**When** did these problems start?

-Are these problems getting **better or worse** over time?

-Is there any **disagreement between the patient and other family members** about the extent or types of problems? yes no
If yes, please explain:

-Please circle if you are having **current difficulties on a day-to-day basis**:

-Difficulty with short-term memory

-Remembering recent conversations

-Remembering recent events

-Remembering where things have been placed

-Remembering appointments

-Remembering the date or day of week

-Remembering to take medication on time

-Remembering the names of people or family

-Remembering the names of things

-Asking the same questions over and over

-Difficulty learning new information

-Problems with cooking (recipes, burning food)

-Problems with taking medication on time

-Forgetting how to operate something you knew in the past (cell phone, remote)

-Social skills

-Difficulty finding words during conversations

-Slurring or mumbling of speech

-Slowed speech

-Difficulty understanding what others are saying

-Difficulty following a story on TV or on a movie

-Difficulty following the plot in a book

-Difficulty remembering what you recently read

-Writing difficulty (changed over time)

-Changes in ability to spell

-Math difficulty (balancing checkbook)

-Difficulty with concentration and attention

-Making decisions and making good judgments

-Problems with driving (directions, getting lost)

-Keeping up with household chores

-Personality changes

EDUCATIONAL HISTORY:

HIGH SCHOOL:

Did you graduate from high school? Yes No

If you did not complete high school: What was the last grade you completed?

Did you obtain a G.E.D.?

What were your **typical grades** in high school: (circle) A-B B-C C-D D-F

Please circle if you had any of the following in school:

-Dyslexia -Learning Disability
-ADD or ADHD -Hyperactivity
-Special Education -Tutoring
-Repeated a grade

After high school, did you attend a trade or vocational school?

COLLEGE:

Did you graduate from college? yes no If yes, what was your degree? (circle): Bachelors Associates

If you attended college but did not graduate, how many years did you attend?

If you attended college: Name of college/university
Major:
Typical grades in college: (circle) A-B B-C C-D D-F

POST GRADUATE EDUCATION:

If you have an advanced degree, complete the following: Degree:
Name of college/university:
Major:

OCCUPATIONAL HISTORY:

Are you (circle): Employed Homemaker Unemployed Retired

Are you (circle): Disabled On short-term medical leave On long-term medical leave On workman's comp.

If currently employed: Where do you work?
For how long?
What is your job title and typical duties?

If retired: What age or year did you retire?
Where did you work?
For how long?
What was your job title and typical duties?

MEDICAL HISTORY:

Please list any prior surgery:	Type of Surgery and Year		Continued
1.)		6.)	
2.)		7.)	
3.)		8.)	
4.)		9.)	
5.)		10.)	

Please list any medication:	Name	Dose (if known)		Continued
1.)			6.)	
2.)			7.)	
3.)			8.)	
4.)			9.)	
5.)			10.)	

Have you ever been **rendered unconscious from a head injury** (such as fall, car accident, sports injury, physical fight)?	yes	no

Do you wear **glasses foe distance or reading**? (circle)	yes	no
Do you have **other problems with vision?** *(Circle): Glaucoma, Cataracts macular degeneration*	yes	no
Do you wear a **hearing aid**? (circle)	yes	no
Do you require a cane, walker, or wheelchair? (circle)	yes	no
When **growing up**, did you have any **significant illnesses or injuries**, which affected your future life? *If so, please describe:*	yes	no

ALCOHOL AND SUBSTANCE USE HISTORY

Do you currently use **alcohol**? (circle) *If yes, what is the typical number of drinks in a week?*	yes	no
Do you currently use any **recreational substances**? *If yes, what substances and how often?*	yes	no
Were you ever a **heavy user** of drugs or alcohol in the past?	yes	no

Have you ever been enrolled in **rehabilitation or hospitalized or alcohol or drug problems**? yes no

MEDICAL CONDITIONS:

*Please circle if any of the following medical problems have been **diagnosed by a doctor**:*

Neurological Conditions:

-Head Injury *(TBI, concussion, coma)*

-Stroke or CVA

-TIA *(transient ischemic attack)*

-Seizure Disorder or Epilepsy

-Brain Infection *(encephalitis or meningitis)*

-Multiple Sclerosis (MS)

-Parkinson's disease

-Dementia of any cause

-Headaches (migraine, tension headaches)

-Other Neurological Disorders not listed: (Please list)

Chronic Pain *Please circle if any of the following medical problems have been **diagnosed by a doctor**:*

-Degenerative spinal disease

-Migraine headaches

-Arthritis *(where?)*

-Bulging disks

-Tension headaches

-Chronic pain of other cause not listed *(Please describe)*

-Please rate the typical daily range of pain:

Without medication: *(no pain)* 0 1 2 3 4 5 6 7 8 9 10 *(excruciating/cannot function)*

With medication: *(no pain)* 0 1 2 3 4 5 6 7 8 9 10 *(excruciating/cannot function)*

Other Medical Problems*: Please circle yes or no if any of the following medical problems have been **diagnosed by a doctor**:*

-Hypertension

-High cholesterol *(hypercholesterolemia)*

-Hypoglycemia

-Cancer or tumor

-Blood Disorders
(Circle which - sickle cell, anemia, hemophilia

-Liver Disease *(Circle which - Cirrhosis, Hepatitis)*

-Gastrointestinal problems
(Circle which - ulcers, irritable bowel syndrome,

-Fibromyalgia

-Diabetes

-Kidney disease or renal failure

-Osteoporosis or Osteopenia

-Breathing or lung problems
(Circle which - COPD, emphysema, asthma)

-Chronic Fatigue Syndrome (must have been diagnosed)

-Thyroid problems *(Circle - hypothyroidism, hyperthyroidism, goiter)*

reflux or GERD, colitis, Crohn's)

-Heart Problems
(Circle which - angina, heart attacks, mitral valve prolapse, congestive heart failure, coronary artery disease)

-HIV, AIDS, or other problems with immune system disorder

-Lupus (SLE)

-Urinary Incontinence *(having accidents)*

-Gait or Walking Problems

-Tremor (Where in body?)

-Excessively tired or fatigued on a frequent basis

-Sleep Disorder (Circle which – insomnia, sleep apnea)

PSYCHIATRIC HISTORY:

Are you <u>currently</u> seeing a psychiatrist, psychologist, psychotherapist, or counselor? Circle: yes no
If yes:
Name of doctor How Long Condition Being Treated Specialty of Doctor

In the <u>past</u>, have you seen a psychiatrist, psychologist, psychotherapist, or counselor? Circle: yes no
If yes:
Name of doctor How Long Condition Being Treated Specialty of Doctor

Have you ever been **hospitalized for a psychiatric or emotional problem**? Circle: yes no
If yes:
Name of Hospital Date Condition Being Treated

Did you have psychological or emotional problems **when growing up**? Circle: yes no
If yes, what type of problems?

Have you had any **major changes or recent stressors** in your life? Circle: yes no
If so, please explain briefly:

What **medications in the past** have you been prescribed for psychiatric difficulty?

Please circle if you have ever been **diagnosed by a psychiatrist, physician, or psychologist** with any of the following:

Depression PTSD (post traumatic stress disorder)

Bipolar Disorder (manic depressive disorder)	Psychosis
Anxiety	Schizoaffective Disorder
Phobias	Schizophrenia
Anxiety/Panic Attacks	Other:
Obsessive-Compulsive Disorder	

Please **circle yes or no** to any of the following that you **currently feel or have recently experienced for at least a 2-week period**:

-Feeling depressed most of the day and nearly every day …….. yes no

-Frequent loss of interest and motivation regarding most activities ……... yes no

-Difficulty experiencing joy or pleasure ……. yes no

-Significant change in appetite …… yes no
If yes, circle whether it is an increase or decrease)

-Significant change in weight when not dieting …… yes no
If yes, circle whether it is an increase or decrease)

-Significant insomnia or need for too much sleep nearly every day …….. yes no
If yes, circle of insomnia, too much sleep, or both

-Significant restlessness or lack of movement to the point that others notice …… yes no

-Frequent fatigue or loss of energy nearly every day …… yes no

-Frequent feelings of worthlessness or excessive or inappropriate guilt …… yes no

-Significant difficulty with thinking, concentration, or making decisions nearly every day ……..yes no

-I frequently feel nervous, anxious, or worried about something ……... yes no

-I often have passive thoughts that life is not worth living or thoughts of death …….yes no

Please circle yes or no if you have experienced any of the following **currently or in the past:**

-There are certain habits that I feel compelled to do in a particular way or very often such as touching, counting, or rearranging things ……yes no

-I have experienced a severe trauma in which I nearly lost or could have lost my life and I cannot stop thinking about it …….. yes no

-There have been times in my life in which I have seriously considered ending my life ……... yes no

-There have been times in my life in which I have attempted suicide ……yes no

-There have been times in my life I seriously intended ending another person's life or attempted to do so ……yes no

-There have been times in which I have heard voices that others cannot hear ……... yes no

-There have been times that I saw visions that others cannot see……yes no

-There have been times that I have felt that I was being watched or spied upon ……... yes no

-There have been times when I have felt that others were out to cause me serious harm …….. yes no

-There have been times in which I felt that others can read my mind or control my thoughts …….. yes no

FAMILY HISTORY OF PSYCHIATRIC PROBLEMS:

Do any of your close relatives have psychological problems or psychiatric problems? yes no

If yes:

	Relationship	Type of Problem
1.)		
2.)		
3.)		
4.)		

LEGAL HISTORY

Have you ever been arrested or convicted of any criminal offense? yes no

If yes, please list: