Neuropsychology Associates, Inc.
PHONE: 401-455-0221

Medical Questionnaire Today's Date: ____/____/____

NAME_____ PHONE_____

ADDRESS_____AGE_____BIRTHDATE___/___/___

Years of schooling _____

Living situation _____

MARITAL STATUS Single Married Widowed Divorced Separated

Children: Daughters _____ Sons _____

Siblings: _____

Current employment status: _____ Current source of income _____

EMPLOYER_____ JOB TITLE_____

What kinds of problems have you been having with your thinking?

_____

_____

_____

How long have these things been a problem? _____

DEVELOPMENTAL HISTORY

During pregnancy, did your mother use any of the following?

	Yes	No	Amount
Alcohol			
Tobacco			
Marijuana			
Other drugs			

In school, did you ever have problems with:

	Yes	No	Indicate nature of problem
Reading			
Spelling			
Writing			
Arithmetic			
Behavior			
Social Adjustment			
Attention Span			
Following Directions			

EDUCATIONAL HISTORY

MD/Doctorate	
Masters	
Bachelors	
Associates	
High School Diploma (age:)	
GED when?	
High school (grade completed:)	
Ever repeat a grade:	
Ever special tutoring or classes:	

MEDICAL HISTORY

Please put a check beside any problem you currently have, or have ever had, in the following areas:

- Cancer _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Kidney Disease _____
- Thyroid Disease _____
- Stroke _____
- Seizure _____
- Headaches _____
- Depression _____
- Hallucinations _____
- Memory Loss _____
- Weight Loss/Gain _____
- Any other major conditions?_____

Are you taking any medications? yes____ no____
If yes,

Medication	Dosage	Dates	Reason	Prescribed by

Have you had any of the following tests?

	Yes	No	Date	Where Done	Result
Eye Exam					
Hearing Test					
EEG					
MRI					
CT Scan					

Physician(s) Name/Address:_____

Do you drive? ☐No ☐Yes If yes, describe any visual difficulty while driving: _____

Ever get lost while driving? ☐No ☐Yes CAR ACCIDENTS? ☐ No ☐Yes

Do you or did you smoke? _____ How long? _____ Packs per day? ____

Have you ever had a head injury? Yes/No
If yes, please describe _____
_____
_____

Is English your first language? yes____ no____

If no, what is your first language?_____
How old were you when you learned to speak English?_____

Have you ever had any of the following symptoms:

	Yes	No	Age	If yes, Explanation
Sleep disturbance				
Changes in appetite				
Reduced energy				
Loss of interest				
Rituals/routines				
Visual hallucinations				
Auditory hallucinations				

Have you ever been treated for:

	Yes	No	Age	If yes, Explanation
Depression				
Anxiety				
Mania				
Obsessive-Compulsive				
Psychosis				

Do you use any of the following?

	Yes	No	If yes, frequency and amount
Alcohol			
Marijuana			
Cocaine			
Inhalants			
Other substances			

Have you ever been hospitalized? yes____ no____
If yes:

Reason for Hospitalization	Age	Length of Stay

Have you received any psychological or psychiatric treatment?
yes____ no____

If yes, please complete below:

Provider	Reason	Dates

Have you ever been arrested? Yes_____ No_____
If yes, describe:

Did you ever serve in the military? Yes_____ No_____

What was your discharge rank and status? _____

FAMILY HISTORY

PARENTS:	have dementia?	Age of onset	Describe	Age if living	Age at death if deceased
Mother	❑ Yes ❑ No				
Father	❑ Yes ❑ No				

Mother's name: _____

Educational level: _____

Occupation: _____

Father's name: _____

Educational level: _____

Occupation: _____

Is there anyone in your immediate or extended family who has (or had) any of the following:

	Yes	No	If yes, who (relation to child)
Learning problems			
Neurological disease			
Seizures (epilepsy)			
Mental retardation			
Attentional problems			
Behavioral problems			
Thyroid Disease			
Cancer			
Kidney Disease			
Alcohol/Substance Abuse			
Stroke			
Depression			
Manic-Depression			
Anxiety Disorder			
Obsessive-Compulsive Disorder			
Other psychiatric problems			
Schizophrenia			
Diabetes			
Cancer			
High blood pressure			
Heart disease			
Alzheimer's Disease			
Dementia			
Other disease/health problem that runs in family			

ADDITIONAL COMMENTS: