Commonwealth Neurobehavioral Associates

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MEDICAL HISTORY QUESTIONNAIRE

The following questions are designed to provide me with information concerning your medical history. The questions are particularly concerned with characteristics or experiences that can affect certain behaviors and emotional functioning. The information you provide in this questionnaire will remain strictly confidential.

NAME:____

DATE OF BIRTH:__________________ **SEX:** ☐ Male ☐ Female

HANDEDNESS: ☐Right ☐Left ☐Mixed or ambidextrous

EDUCATION: Highest level of Education ______________________________

Please indicate highest degree or certification achieved:_________________________

OCCUPATION: (If retired, indicate occupation prior to retirement)

____

MEDICATIONS: Please list current medications (including dosage):

____

____

____

____

____

Please answer each of the following questions on the following pages to the best of your ability.

Mark the box in front of the most accurate response.

During her pregnancy with you, did your mother have any of the following medical problems:

Required bed rest or hospitalization for medical problems? ☐ Yes ☐ No ☐ Don't know
Used alcohol or other non-prescription drugs? ☐ Yes ☐ No ☐ Don't know
Used prescribed medication other than vitamins? ☐ Yes ☐ No ☐ Don't know
Smoked cigarettes? ☐ Yes ☐ No ☐ Don't know
Was exposed to lead, solvents, or other toxic substances? ☐ Yes ☐ No ☐ Don't know
Had preeclampsia (high blood pressure due to pregnancy)? ☐ Yes ☐ No ☐ Don't know
Suffered a serious physical injury? ☐ Yes ☐ No ☐ Don't know
Suffered severe morning sickness? ☐ Yes ☐ No ☐ Don't know

During your birth, did you have any of the following problems or complications?

Born prematurely? ☐ Yes ☐ No ☐ Don't know
Cord wrapped around you at birth? ☐ Yes ☐ No ☐ Don't know
Forceps used during your delivery? ☐ Yes ☐ No ☐ Don't know
Lack of oxygen or other fetal distress? ☐ Yes ☐ No ☐ Don't know
Low "APGAR" scores (poor vital signs at birth)? ☐ Yes ☐ No ☐ Don't know
Treated in an infant Intensive Care Unit after your birth? ☐ Yes ☐ No ☐ Don't know
Any other birth complications? ☐ Yes ☐ No ☐ Don't know
If yes, please specify?____

Did you experience any delays in your development as a child, such as:

Walking late (after one year of age)? ☐ Yes ☐ No ☐ Don't know
Talking late (after two years of age)? ☐ Yes ☐ No ☐ Don't know
Bedwetting (after five years of age)? ☐ Yes ☐ No ☐ Don't know
"Tics" (involuntary movements or sounds such as grunting)? ☐ Yes ☐ No ☐ Don't know
Parents considered you a "difficult" baby? ☐ Yes ☐ No ☐ Don't know

Did you experience any learning disabilities or other school problems, such as:

Were you diagnosed as having attention deficit or hyperactivity? ☐ Yes ☐ No
Were you diagnosed as having a learning disability? ☐ Yes ☐ No
Were you diagnosed as "retarded" or developmentally delayed? ☐ Yes ☐ No
Were you placed in an ungraded or special classroom? ☐ Yes ☐ No
Did you receive any resource help, special education, or tutoring? ☐ Yes ☐ No
Did you receive speech therapy or physical therapy? ☐ Yes ☐ No
Did you fail any courses in grammar school? ☐ Yes ☐ No
If so, which courses?____
Did you repeat any grades in grammar school? ☐ Yes ☐ No
If so, which grades?____
Did you fail any courses in high school? ☐ Yes ☐ No
If so, which courses?____
Did you repeat any grades in high school? ☐ Yes ☐ No
If so, which grades? ____

For the next two sets of questions, please mark ALL boxes that apply.

Either as a child or as an adult, have you had any of the following problems:

Poor coordination compared to others?	☐ Child	☐ Adult	☐ No
Particular problems with arithmetic or other math?	☐ Child	☐ Adult	☐ No
Problems with art, drawing, or putting things together?	☐ Child	☐ Adult	☐ No
Trouble following travel directions or getting lost frequently?	☐ Child	☐ Adult	☐ No
Difficulty interpreting the emotions of others?	☐ Child	☐ Adult	☐ No
Difficulty communicating your own emotions accurately?	☐ Child	☐ Adult	☐ No
Extreme shyness or awkwardness in social situation?	☐ Child	☐ Adult	☐ No
Difficulty making friends, a tendency to be social isolated?	☐ Child	☐ Adult	☐ No
Difficulty with sexual intimacy or reduced sex drive?	☐ Adolescent	☐ Adult	☐ No

Either as a child or as an adult, have your teachers, parents, or other close relative ever described you as someone who:

Couldn't concentrate, or couldn't pay attention for long?	☐ Child	☐ Adult	☐ No
Couldn't sit still, was restless or hyperactive?	☐ Child	☐ Adult	☐ No
Was fidgety?	☐ Child	☐ Adult	☐ No
Daydreamed or lost in your thoughts?	☐ Child	☐ Adult	☐ No
Had difficulty following directions?	☐ Child	☐ Adult	☐ No
Talked out of turn?	☐ Child	☐ Adult	☐ No
Did messy work?	☐ Child	☐ Adult	☐ No
Failed to finish things you started?	☐ Child	☐ Adult	☐ No
Was inattentive or easily distracted?	☐ Child	☐ Adult	☐ No
Talked too much?	☐ Child	☐ Adult	☐ No
Failed to carry out assigned tasks?	☐ Child	☐ Adult	☐ No
Was easily angered, had frequent temper tantrums or rages?	☐ Child	☐ Adult	☐ No

Have you had any of the following neurological problems:

Head injury with loss of consciousness or confusion?	☐ Yes	☐ No
Seizures, epilepsy, or "fits"?	☐ Yes	☐ No
Stroke, brain hemorrhage, "TIA's" or other vascular problems?	☐ Yes	☐ No
High fever, meningitis, encephalitis, or other brain infections?	☐ Yes	☐ No
Brain tumor?	☐ Yes	☐ No
Loss of oxygen, drowning, or suffocation?	☐ Yes	☐ No
Drug or alcohol overdose?	☐ Yes	☐ No
Exposure to toxic substances (such as lead, mercury, solvents)?	☐ Yes	☐ No
Severe or persistent headache, or migraine?	☐ Yes	☐ No
Parkinson's disease or other movement disorder?	☐ Yes	☐ No
Alzheimer's disease or other dementia?	☐ Yes	☐ No
Multiple sclerosis?	☐ Yes	☐ No
Other neurologic disease or damage?	☐ Yes	☐ No

Specify: ____

Have you had any of the following medical problems:

Heart attack or heart failure? ☐ Yes ☐ No
High blood pressure? ☐ Yes ☐ No
Liver disease, hepatitis, cirrhosis, or jaundice? ☐ Yes ☐ No
Kidney disease or dialysis? ☐ Yes ☐ No
Diabetes, thyroid disease or other endocrine (gland) disorder? ☐ Yes ☐ No
Vitamin deficiency? ☐ Yes ☐ No
Cancer? ☐ Yes ☐ No
Other serious medical problem? ☐ Yes ☐ No
Specify:____

Have you had treatment in the past for emotional or psychiatric problems such as:

Hospitalization for emotional or psychiatric problems
(including alcohol or drug abuse)? ☐ Yes ☐ No
Specify:____
Prescribed medication for emotional or psychiatric problems? ☐ Yes ☐ No
Treated with ECT (electroconvulsive or "shock" therapy)? ☐ Yes ☐ No
Had brain surgery for psychiatric or emotional problems? ☐ Yes ☐ No

Please answer the following questions about your alcohol and/or drug use during the past two years:

Have attempted to cut down or control your use? ☐ Yes ☐ No
Have felt annoyed at criticism of use? ☐ Yes ☐ No
Have felt guilty of use or consequences of use? ☐ Yes ☐ No
Used alcohol or drugs as an eye-opener? ☐ Yes ☐ No
Perceived an alcohol or drug problem? ☐ Yes ☐ No
Has your use of alcohol and/or drugs created a problem with your health?
☐ Yes ☐ No
Have you neglected obligations, family, or work,
because you were drinking or using drugs? ☐ Yes ☐ No

Please answer the following questions about your use of drugs:

Have you ever used drugs not prescribed for you
(do not include over-the-counter medications)? ☐ Yes ☐ No

If you answered "no" to the previous question, please skip the next section.
If your answer was "yes," please indicate the types of drugs you have used.

Barbiturates or "downers" (e.g. Seconal, Quaaludes, etc.)? ☐ Yes ☐ No
Opiates (e.g. heroin, methadone, Demerol, "smack")? ☐ Yes ☐ No
Amphetamines or "uppers" (e.g. Dexedrine, meth)? ☐ Yes ☐ No
Cocaine or "crack"? ☐ Yes ☐ No
Marijuana or hashish? ☐ Yes ☐ No
Hallucinogens (e.g. LSD or "acid", PCP or "angel dust", etc.)? ☐ Yes ☐ No

Has anyone in your FAMILY had any of these neurological conditions?

Seizures, epilepsy, or "fits"? ☐ Yes ☐ No ☐ Don't know

Stroke, brain hemorrhage, "TIA's" or other vascular problems? ☐ Yes ☐ No ☐ Don't know

Fainting or dizzy spells? ☐ Yes ☐ No ☐ Don't know

Brain tumor? ☐ Yes ☐ No ☐ Don't know

Syphilis or other venereal disease? ☐ Yes ☐ No ☐ Don't know

Severe or persistent headache, or migraine? ☐ Yes ☐ No ☐ Don't know

Parkinson's disease or other movement disorder? ☐ Yes ☐ No ☐ Don't know

Alzheimer's disease or other dementia? ☐ Yes ☐ No ☐ Don't know

Other neurologic disease or damage? ☐ Yes ☐ No ☐ Don't know

Has anyone in your FAMILY had any of the following general medical problems:

Heart attack or heart failure? ☐ Yes ☐ No

High blood pressure? ☐ Yes ☐ No

Liver disease, hepatitis, cirrhosis, or jaundice? ☐ Yes ☐ No

Kidney disease or dialysis? ☐ Yes ☐ No

Diabetes, thyroid disease or other endocrine (gland) disorder? ☐ Yes ☐ No

Vitamin deficiency? ☐ Yes ☐ No

Cancer? ☐ Yes ☐ No

Other serious medical problem? ☐ Yes ☐ No

Specify:____

Has anyone in your FAMILY had any treatment in the past for emotional or psychiatric problems such as:

Formal diagnosis of emotional or psychiatric problems? ☐ Yes ☐ No ☐ Don't know

Specify (e.g. mother had depression)________________________________

Hospitalization for emotional or psychiatric problems? ☐ Yes ☐ No ☐ Don't know

Specify ____

Thank you for providing this information. Please bring this with you when you come for your appointment.