The Miriam Hospital
A Lifespan Partner

164 Summit Avenue
Providence, RI 02906

HEALTH AND HISTORY QUESTIONNAIRE

(All information supplied in this questionnaire is strictly confidential)

APPLICANT'S NAME: _____ Date: ___/___/___

ADDRESS: _____

_____

_____

HOME PHONE: ( ) _____

WORK PHONE ( ) _____

SS# _____

AGE: ____ GENDER ____ BIRTHDATE: ___/___/___

REFERRED BY: _____

Medical Insurance Name and Number:

_____

_____

PRIMARY CONTACT PERSON

NAME: _____

ADDRESS: _____

_____

RELATIONSHIP: _____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

NAME OF PERSON COMPLETING THIS FORM: _____
first last

RELATIONSHIP:_____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

PRINCIPAL FAMILY PHYSICIAN

NAME: _____
first last

OFFICE PHONE: ( ) _____

ASSESSMENT OF PRESENT CONDITION:

1. HOW LONG SINCE FIRST BECOMING FORGETFUL, CONFUSED, DEPRESSED, ETC?

HOW MANY	MONTHS _____	or	YEARS _____	(Estimate)
2. WAS THE ONSET OF SYMPTOMS	SUDDEN _____	or	GRADUAL _____	(Check one)
3. HAS THE CONDITON GOTTEN WORSE	GRADUALLY _____	or	SUDDENLY _____	(Check one)
4. IS THE CONDITION	INTERMITTENT _____	or	CONSTANT _____	(Check one)

PLEASE DESCRIBE CURRENT BEHAVIORAL AND MEMORY PROBLEMS (ADD ANY DETAILS YOU THINK ARE IMPORTANT):

_____

_____

_____

_____

_____

DOES APPLICANT ATTEND ADULT DAY CARE OR SENIOR CENTER? ____YES ____NO. IF YES, WHERE?

_____

DOES FAMILY ATTEND A SUPPORT GROUP? ____YES ____NO

OCCUPATION (TYPE OF WORK)

_____

CURRENTLY EMPLOYED? ____YES ____NO RETIRED? ____YES ____NO YEARS SINCE RETIRING:_____

HIGHEST LEVEL OF EDUCATION: _____ DEGREES:_____

DOES PATIENT DRIVE? ____YES ____NO

ARE PATIENT'S PARENTS STILL ALIVE? FATHER: ____YES ____NO MOTHER: ____YES ____NO

IF DECEASED, WHAT WAS THE CAUSE OF THE DEATH AND AT WHAT AGE?

FATHER: (cause) _____ AGE: _____

MOTHER: (cause) _____ AGE: _____

HISTORY OF DEMENTIA (MEMORY LOSS) IN PARENTS? FATHER: ____YES ____NO MOTHER: ____YES ____NO

IF KNOWN, GIVE SPECIFIC DIAGNOSIS: _____

_____

DOES APPLICANT HAVE SIBLINGS? ____YES ____NO IF YES, LIST NAMES, HEALTH STATUS AND AGE BELOW:

NAME:	HEALTH STATUS:	AGE:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HISTORY OF DEMENTIA (MEMORY LOSS) IN SIBLINGS? ____YES ____NO ____NA (NO SIBLINGS)

IF KNOWN, GIVE SPECIFIC DIAGNOSIS: _____

_____

DOES APPLICANT HAVE CHILDREN? ____YES ____NO. IF YES, LIST NAMES, HEALTH STATUS, RESIDENCE AND AGE BELOW:

NAME:	HEALTH STATUS:	RESIDENCE:	AGE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

OPERATIONS AND OTHER HOSPITALIZATION:

DATE	TYPE OF OPERATION	TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL PROBLEMS:

___HEART ATTACK	___SPLEEN DISEASE	___ASTHMA
___ANGINA	___LIVER DISEASE	___DIABETES
___ARRYTHMIA	___GASTRIC DISEASE	___BLINDNESS
___PACE MAKER	___BOWEL DISEASE	___THYROID
___HEART ATTACK	___CANCER	___GLAUCOMA
___HIGH BLOOD PRESSURE	___LUNG DISEASE	___DEAFNESS
___LOW BLOOD PRESSURE	___BRONCHIAL DISEASE	___VENEREAL DISEASE
___KIDNEY DISEASE	___ALLERGIES	___PAGET'S DISEASE

OTHER PROBLEM(S) (PLEASE SPECIFY): _____

_____

_____

PLEASE GIVE DETAILS OF CHECKED ITEMS ABOVE:

_____

_____

_____

NEUROLOGICAL PROBLEMS:

___HEAD INJURY WITHOUT UNCONSCIOUSNESS	___BRAIN SURGERY	___STROKE
___HEAD INJURY WITH UNCONSCIOUSNESS	____MIGRAINE	____SPEECH DISORDERS
____MENINGITIS	____FAINTING SPELLS	____FLACCID OR SPASTIC
____ENCEPHALITIS	____DIZZY SPELLS	____PARALYSIS
____POLYIOMYELITIS	____EPILEPSY/SEIZURES	____APPLICANT WAS AN AMATEUR OR PROFESSIONAL BOXER
____MULTIPLE SCLEROSIS	____PARKINSON'S DISEASE	____LOU GEHRIG'S DISEASE

OTHER PROBLEM(S) (PLEASE SPECIFY):

_____

_____

_____

_____

PSYCHIATRIC PROBLEMS:

____PSYCHIATRIC HOSPITALIZATION(S)

____PSYCHIATRIC TREATMENT

____SCHIZOPHRENIA

____DEPRESSION

____ALCOHOLISM

____DRUG ABUSE

PLEASE LIST ALL CURRENT MEDICATIONS WITH THEIR TRADE NAMES:

NAME OF MEDICATION	DOSAGE/FREQUENCY	REASON

PLEASE LIST ANY HISTORY OF ADVERSE REACTIONS TO MEDICATIONS:

_____

_____