HEALTH QUESTIONNAIRE

Please answer every question. This will help us complete your neurological evaluation. Please give dates and facts for each "yes" answer. Otherwise, write "no." Do not leave blanks. This information is confidential and will only be released with your consent. **Bring this to your first visit at the Center.**

Name: _____
Last First Middle Maiden name

Date of birth: _____ Today's date: _____
Month Day Year Month Day Year

Ever evaluated at Columbia Presbyterian Medical Center? ☐YES ☐NO If yes, by whom? _____

Ever evaluated at the New York State Psychiatric Institute? ☐YES ☐NO If yes, by whom? _____

Who is your primary care practitioner or family doctor? _____

Do you have health insurance? ☐YES ☐NO

If yes, please indicate what you have: ☐Medicare ☐Medicaid ☐Private _____

PAST MEDICAL HISTORY

Birth injuries or illnesses? _____

Serious childhood (0-12 years) injuries or illnesses or hospitalizations? _____

Serious teenage (13-17 years) injuries or illnesses or hospitalizations? _____

Serious adult injuries requiring hospitalization? _____

Serious adult illnesses requiring hospitalization? _____

Major surgery that required general anesthesia (put to sleep)? _____

Minor surgery that did not require general anesthesia? _____

_____

PERSONAL HISTORY

Handedness: ☐ right ☐ left ☐ use both hands for different tasks

Highest level of education completed: _____

Marital status: _____

Children (names and ages) a) _____

b) _____

c) _____

d) _____

Current Occupation/Employment: _____

Past Employment: _____

Who lives with you now? _____

What time do you get into bed? _____ Do you move around a lot in your sleep? ☐ YES ☐ NO

What time do you fall asleep? _____ Are you usually very tired during the day? ☐ YES ☐ NO

What time do you wake up? _____ Do you often fall asleep during the day? ☐ YES ☐ NO

FAMILY HISTORY

Is your mother living? _____

If not, how old was she at the time of her death? _____

Cause of her death: _____

Is your father living? _____

If not, how old was your father at the time of his death? _____

Cause of his death:

If your parent had Huntington's disease, at what age did it begin?

Are all your brothers and sisters living?

If not, who died? At what age? What was cause of death?

Are there any illnesses which run in your family?

Reason for this neurological evaluation:

RECENT PROBLEMS (CHECK ALL THE PROBLEMS YOU HAVE.)

- ☐ Loss of taste or smell
- ☐ Deceased memory or thinking ability
- ☐ Trouble with reading or writing
- ☐ Loss of self-confidence or change in mood
- ☐ Change in vision
- ☐ Difficulty swallowing, choking or gagging
- ☐ Difficulty speaking
- ☐ Weakness or numbness in one part of body
- ☐ Decrease sexual interest (not performance)
- ☐ Lightheadedness on standing
- ☐ Dizziness
- ☐ Blurred or double vision
- ☐ Headache
- ☐ Clumsiness
- ☐ Walking or balance problem
- ☐ Recent falls or near falls
- ☐ Tremor or involuntary movements
- ☐ Loss of urine control

☐ Fevers	☐ Chills	☐ Night sweats	☐ Weight loss
☐ Rashes	☐ Dry skin	☐ Eczema	☐ Dandruff
☐ Dry eyes	☐ Red eyes	☐ Itchy eyes	☐ Eye pain

☐ Drooling	☐ Dry mouth	☐ Mouth ulcers	☐ Dentures don't fit
☐ Ringing in ears	☐ Difficulty hearing	☐ Nasal congestion	☐ Sore throat
☐ Shortness of breath	☐ Wheezing	☐ Coughing	☐ Snoring
☐ Constipation	☐ Diarrhea	☐ Bloody stool	☐ Black stool
☐ Difficulty w/ erections	☐ Difficulty urinating		
☐ Abnormal bleeding	☐ Anemia	☐ Easy bruising	
☐ Swollen joints	☐ Painful joints	☐ Muscle pain	
☐ Chest pain	☐ Palpitations	☐ Short of breath when exerting	
☐ Hot flashes	☐ Thirsty all the time	☐ Need to urinate all the time	
☐ Loss of appetite	☐ Feelings of sadness	☐ Feelings of hopelessness	
☐ Loss of motivation	☐ Anxiety or fearfulness	☐ Loss of interest in doing things	

HAVE YOU EVER HAD:

Head trauma with loss of consciousness? ☐ YES ☐ NO _____

Any neurological problems, other than HD? ☐ YES ☐ NO _____

Any past psychiatric hospitalizations? ☐ YES ☐ NO _____

Do you currently drink alcohol? ☐ YES ☐ NO If yes, how many drinks per week? _____

In the past, did you smoke tobacco? ☐ YES ☐ NO If yes, how many packs per day? _____

Do you currently smoke tobacco? ☐ YES ☐ NO If yes, how many packs per day? _____

List prescribed medications you are currently taking, the dosages, and the date you started this medication. If there are too many to name, please ask your pharmacist for a print-out of your medication history for the past two years. (Many pharmacies provide this service as a courtesy).

a) _____

b) _____

c) _____

d) _____

e) _____

f) _____

List non-prescription medications (including vitamins, aspirin, over-the-counter & health food supplements)

a) _____

b) _____

c) _____

d) _____

e) _____

f) _____

g) _____

h) _____

i) _____

j) _____

Please list any allergies you have to foods, inhalants, and/or drugs:

Do you have any other active health problems? ☐YES ☐NO If yes, please describe.

Are you interested in participating in clinical research studies in the future? ☐YES ☐NO

THANK YOU ANSWERING THESE QUESTIONS.