BRIGHAM AND WOMEN'S HOSPITAL
Specializing in care for a lifetime

Center for Brain/Mind Medicine

HARVARD MEDICAL SCHOOL
Teaching Affiliate

PATIENT:

Today's Date: _____

Name:
Date of birth:
Address:

Home Phone:
Work Phone:

Residence is:

☐ Private Residence - ***(Please circle one)***
Alone With Significant Other
With Spouse With Friend
With Family

☐ Apartment attached to Cargiver/Family residence
☐ Retirement Community
☐ Assisted Living
☐ Institution (Date admitted? _____)
☐ Dormitory
☐ Other

Please complete the following questionnaire which seeks information about your past medical history, medication use and related issues. This confidential information will assist your clinician in providing the best care possible. Further information will be obtained during your visit, and we will try to address any questions that you have.

REASON(S) FOR VISIT:

☐ Trouble remembering
☐ Difficulty with attention and concentration
☐ Changes with personality or behavior
☐ Feeling depressed
☐ Difficulty with school/learning
☐ Problem with reading or writing
☐ Difficulty speaking or finding words
☐ Feeling anxious
☐ Other:_____

Please give a brief description:

RELEASE INFORMATION: Please list any other healthcare providers. For example, your primary care physician, cardiologist, or the doctor who referred you to our clinic.

Doctor:

Address:

Phone Number:

Doctor:

Address:

Phone Number:

Are you interested in learning more about participating in clinical research studies? ☐ Yes ☐ No

CURRENT MEDICATIONS: Please list current medications and dose. Bring or attach a list if necessary.

_____ _____

_____ _____

_____ _____

CURRENT OTC MEDICATIONS: Please list current over-the-counter medications (OTC), including vitamins, herbal remedies or supplements, and medications for pain, sleep, etc…

_____ _____

_____ _____

_____ _____

PREVIOUS MEDICATIONS: Please indicate if you felt the medication was helpful.

_____ _____

_____ _____

Have you ever used an antidepressant drug such as Prozac, Zoloft, Paxil, Celexa, Lexapro, or Wellbutrin?

☐ Yes
☐ No

Do you experience chronic pain? ☐ Yes ☐ No

Please explain:

Do you have any drug allergies?

☐ Yes
☐ No

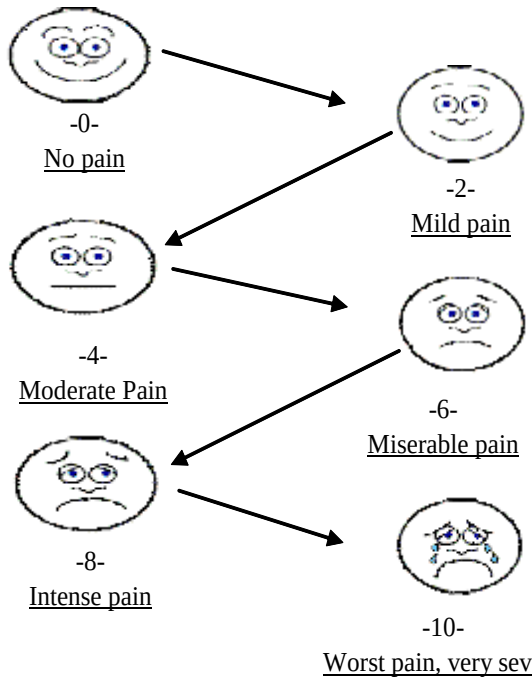
Specify: _____

_____

What happens? _____

_____

Which best describes any pain that you are having?



Do you smoke cigarettes? ☐ Yes ☐ No

How much alcohol do you consume in a week? _____

Safety

Are you concerned that someone at home or in your neighborhood will hurt you?	Yes	No
Did you receive a copy of a pamphlet titled, "We Care About Your Safety?"	Yes	No
Do you understand how to prevent the spread of germs?	Yes	No
If having a procedure, do you understand how we will keep you safe?	Yes	No

Do you have additional questions or concerns about patient safety?

Family History Do you have a family member affected with:

Condition	**Yes**	**No**	**type/affected relative**	**Condition**	**Yes**	**No**	**type/affected relative**
Brain Tumor	☐	☐		Muscle Disease	☐	☐	
Seizures or Epilepsy	☐	☐		Neuropathy	☐	☐	
Dementia	☐	☐		Other Neurological Disorder	☐	☐	
Parkinson's	☐	☐		Hypertension	☐	☐	
Multiple Sclerosis	☐	☐		Diabetes	☐	☐	
Thyroid Disease	☐	☐		Migraines	☐	☐	

Write other conditions _____
_____
_____

PATIENT MEDICAL HISTORY/REVIEW OF SYMPTOMS:

Have you ever had any of the following, or are you having difficulties with any of the following items? (Please check even if treated or controlled)

General
- ☐ Frequent fevers/chills
- ☐ Body aches
- ☐ Fatigue
- ☐ Unexpected Weight Changes
- ☐ Other

Skin
- ☐ Mole changes/growth
- ☐ Skin rashes
- ☐ Itchy skin
- ☐ Skin dryness
- ☐ Other

Lymphatic
- ☐ Bruising
- ☐ Bleeding
- ☐ Swollen glands
- ☐ Immune problems
- ☐ Other

Lungs/Heart
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Leg cramps
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Other

Psychological
- ☐ Frequent crying
- ☐ Being afraid or having fearful thoughts
- ☐ Suicidal thoughts
- ☐ Insomnia
- ☐ Problems oversleeping
- ☐ Treatment for depression
- ☐ Therapy for emotional problems
- ☐ Tension, Stress or Anxiety
- ☐ Major mental illness
- ☐ Addiction(s)
- ☐ Trouble with the law
- ☐ Other

Muscles
- ☐ Painful joints
- ☐ Stiffness
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Other

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Hepatitis
- ☐ Recent significant weight change
- ☐ Heartburn
- ☐ Ulcers
- ☐ Recent change in tastes or food preferences
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other

Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Unsteadiness while walking
- ☐ Numbness
- ☐ Weakness
- ☐ Drowsiness
- ☐ Head injury or concussion
- ☐ Tremor/ shaking
- ☐ Memory problems
- ☐ Seizures
- ☐ Stroke
- ☐ Falls
- ☐ Other

Endocrine and Genitourinary
- ☐ Diabetes
- ☐ Thyroid trouble
- ☐ Excessive sweating or night sweats
- ☐ Kidney disease
- ☐ Hot flashes or heat intolerance
- ☐ Sexual difficulties
- ☐ Unusual discharge
- ☐ Pain or burning w/ urination
- ☐ Change in urinary frequency
- ☐ Sexually transmitted disease
- ☐ Removal of uterus
- ☐ Removal of ovaries
- ☐ Other

Have you ever had a picture or image taken of your brain? ☐ Yes ☐ No
If available, please bring a copy of this report.

Previous surgeries or procedures (include dates if known):

_____

_____

PATIENT DETAILS AND DEMOGRAPHICS:

Handedness:
- ☐ Right
- ☐ Left
- ☐ Ambidextrous

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Other

Did you learn English after a first language?
- ☐ Yes
- ☐ No

Education:
- ☐ Elementary School -5yrs
- ☐ Middle School - 8yrs
- ☐ High School (Some) - 10yrs
- ☐ High School Graduate -12yrs
- ☐ College (Associate's) -14yrs
- ☐ College (Bachelor's) -16yrs
- ☐ Graduate or Professional School -18+ yrs

Type of Work: _____
(please give previous if retired)

Retired?
- ☐ Yes
- ☐ No

Current or previous average hours/wk:

_____

Race and Ethnicity: (select one or more)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Caucasian
- ☐ Other: _____

Please use this space to explain any checked items from above, any answers marked 'Other', or any concerns you'd like us to know about.

Do you have a Health Care Proxy? (circle one) Yes No

If yes, please list and bring copy:

_____

If no, and you would like more information, please ask our receptionist.

Research Studies

Are you interested in learning more about the kind of research conducted at our Center?

(circle one) Yes No

Can we contact you?

(circle one) Yes No

Signatures

Date:_____Time:_____Patient Signature:_____

Date:_____Time:_____Physician Signature:_____Clinical ID#_____