THE MEMORY CENTER OF NORTHEASTERN NEW YORK
EMPIRE NEUROLOGY, P.C.
1182 TROY-SCHENECTADY ROAD, STE 203
LATHAM, NY 12110
P: (518) 389-6876 / F: (518) 785-5000

In order to obtain the most complete information possible, we ask you to complete this form prior to your appointment and bring it with you. The words "you" and "your" refer to the patient and not to someone else completing the form on his or her behalf. Please elaborate on any "yes" answers using the reverse side of this form if needed.

PART I: GENERAL PATIENT INFORMATION

Name: ______________________________ Family Physician: ____________________

Address: ___________________________ City: _____________ State: ___ Zip: ______

Date of Birth: _______________ Age: ___________ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Caregiver: _______________________________ Phone: ___________________________

POA: ___________________________________ Phone: ___________________________

PART II: PERSONAL MEDICAL HISTORY

Have you (or your family) noticed any of the following?

☐ Memory Loss ☐ Word finding problems ☐ Confusion

☐ Getting lost ☐ Wandering ☐ Depression

☐ Agitation/irritability ☐ Aggression ☐ Suspiciousness

☐ Apathy (loss of interest, drive, or motivation) ☐ Anxiety

☐ Hallucinations (seeing, hearing, or otherwise sensing things not present)

☐ Delusions (ideas or beliefs not based in reality)

☐ Inability to do complex activities (shopping, cooking, handling money)

☐ Inability to do basic self-care (bathing, grooming, dressing, toileting)

Have you (or your family) noticed any of the following?

☐ Loss of bladder control ☐ Loss of bowel control ☐ Sleep problems
☐ Loss of appetite ☐ Weight loss

When did these symptoms start? ____

How have they changed over time? ____

Please check if any of these tests have been done:

☐ MRI of Brain ☐ SPECT or PET Scan ☐ EEG

☐ Carotid Doppler ☐ Neuropsychological Tests ☐ Blood Tests for Memory Loss (Thyroid, B12, RPR)

☐ CT Scan/Doppler

Dates of Exams: ______________________ Where Performed: ______________________

______________________ ______________________

______________________ ______________________

Is there any reason why you cannot have a MRI scan? ☐ No ☐ Yes (list below)

____

Have you ever been told you had a stroke or have you experienced sudden weakness, numbness, clumsiness, or had trouble with language or loss of vision? ☐ No ☐ Yes (If yes, please explain) ____

____

Have you ever been hospitalized for a medical condition? ☐ No ☐ Yes (list below)

Have you been hospitalized for psychiatric problems? ☐ No ☐ Yes (list below)

Have you ever had any surgery or operations? ☐ No ☐ Yes (list below)

____

____

____

____

---FOR WOMEN ONLY---

When was your last period? ______________________ ***(month/day/year)***

How many pregnancies have you had? ________________

Are you, or were you, on estrogen replacement therapy? ☐ ***No*** ☐ ***Yes*** __________ ***(yrs)***

Additional Information: (i.e. hysterectomy, uterine ablation, etc.)

____

____

PART III: MEDICATION HISTORY

Please list any allergies: ____

____

Are you taking, or have you taken, any of the following medications?

	Medication		Taking now?	Side Effects?
☐	Cognex (tacrine)	______________ mg _________ times per day	☐	☐
☐	Aricept (donepezil)	____________ mg __________ times per day	☐	☐
☐	Exelon (rivastigmine)	___________mg __________times per day	☐	☐
☐	Metrifonate	__________________mg __________times per day	☐	☐
☐	Vitamin E	___________________mg __________ times per day	☐	☐
☐	Ginkgo Biloba	________________ mg __________times per day	☐	☐
☐	Aspirin	_______________________ mg __________times per day	☐	☐
☐	Anti-inflammatory (Naprosyn, Aleve, Relefan, Celebrex, etc)	_____________ mg __________times per day	☐	☐

Please list all other medications and supplements you are currently taking:

Medication Name	Strength	Frequency
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________
__________________________	_______________________	_____________________

Can you swallow capsules and pills whole? ☐ Yes ☐ No

PART IV: REVIEW OF SYSTEMS

Height ___________________________ Weight __________________________

Please mark if you have, or have had, any of the illnesses or symptoms listed:

GENERAL	Yes	No
Tires easily, weak	☐	☐
Night sweats	☐	☐
Fevers	☐	☐

NERVOUS SYSTEM	Yes	No
Headaches	☐	☐
Tremors	☐	☐
Weakness	☐	☐
Numbness	☐	☐
Clumsiness/Unsteady	☐	☐
Speech Problems	☐	☐
Swallowing Problems	☐	☐
Fainting	☐	☐
Blackouts	☐	☐
Dizziness	☐	☐
Head Trauma	☐	☐

SKIN	Yes	No
Rash or Hives	☐	☐
Change in Skin Color	☐	☐
Any Birthmarks?	☐	☐
Moles, Cysts, Sores	☐	☐

GLANDS/ENDOCRINE	Yes	No
Thyroid Disorders	☐	☐
Diabetes	☐	☐

EYES/EARS/NOSE/THROAT	Yes	No
Change in Vision	☐	☐
Blurred Vision/Double Vision	☐	☐
Eye Pain	☐	☐
Glaucoma	☐	☐
Hearing Loss	☐	☐
Ringing in the Ears	☐	☐
Frequent Nosebleeds	☐	☐
Sinus Problems	☐	☐
Change in Taste/Smell	☐	☐
Sore Throat	☐	☐
Hoarseness	☐	☐

LUNGS/HEART	Yes	No
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Persistent Cough	☐	☐
Coughing Sputum	☐	☐
Coughing Blood	☐	☐
Short of Breath	☐	☐
Excessive Snoring	☐	☐
Chest Pain/Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Swollen Ankles	☐	☐
High Blood Pressure	☐	☐
Pacemaker	☐	☐

DIGESTIVE	Yes	No
Nausea/Vomiting	☐	☐
Ulcers	☐	☐
Constipation	☐	☐
Abdominal Pain	☐	☐
Hepatitis/Jaundice	☐	☐
Black/Bloody Stool	☐	☐

KIDNEY/URINARY	Yes	No
Kidney Disease	☐	☐
Urinary Frequency	☐	☐
Pain/Burning	☐	☐
Blood/Discharge	☐	☐

OTHER	Yes	No
Arthritis/Rheumatism	☐	☐
Back/Joint Pain	☐	☐
Broken Bones	☐	☐
Cancer/Tumors	☐	☐
AIDS/HIV Infection	☐	☐
Bruising/Clotting Problem	☐	☐
Anemia	☐	☐
Transfusions	☐	☐
Sexual /Dysfunction	☐	☐

Any additional illnesses/symptoms? ____

____

____

____

PART V: FAMILY MEDICAL HISTORY

Is your mother alive? ☐ Yes, age ______ ☐ No, died at age ____ of _________

Is your father alive? ☐ Yes, age ______ ☐ No, died at age ____ of _________

How many brothers? _______________________ Sisters? ______________________

Do any of these diseases run in your family?

- ☐ Alzheimer's disease/dementia/senility/hardening of the arteries?
- ☐ Stroke/TIA (Transient Ischemic Attacks) Mini Strokes?
- ☐ Depression, Nervous Breakdowns, Schizophrenia, Bipolar/Manic Depression, Anxiety Disorders, Learning Disorders? (Circle all that apply)
- ☐ Diabetes, Hypertension/High Blood Pressure, Epilepsy/Seizures, Migraine, Cancer? (Circle all that apply)

Any other family tendencies/illnesses? ____

PART VI: PERSONAL INFORMATION

Education Level: _________ Occupation: ____________________ Retired? ☐ Yes ☐ No

How many children do you have? ___________________ How many grandchildren? ________

Who lives at home with you? ________________________________

Do you smoke? ☐ No ☐ Yes, Amount/Type __________________________
Do you drink alcohol? ☐ No ☐ Yes, Amount/Frequency ______________________
Have you used drugs? ☐ No ☐ Yes, Amount/Type __________________________

Do you drive a car? ☐ Yes ☐ No, Never Have ☐ No, Stopped ____ (when)

Name of person completing this form: ____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: __________

PART VI: CLINICAL RESEARCH

Our office participates in clinical research trials. If applicable/appropriate, would you like to be contacted about clinical research opportunities if they become available in the future?

☐ No ☐ Yes, (please fill in the contact name and preferred method of contact)

Contact Name (if other than patient): ____

Phone Number: ____

Address: ____

E-Mail: ____

Thank You