Patient Name: ___________________________
Date of Birth: ___________________________
MRN: ___________________________
Encounter #: ___________________________

NMG-NEUROLOGY
Huntington's Disease Clinic
MEDICAL BACKGROUND AND INFORMATION FORM

Thank you for taking the time to complete this questionnaire. Rather than taking up much of your appointment time collecting this information and taking the chance that something will be overlooked, please go through this form and fill it out to the best of your ability. This information will be reviewed with you and will help in understanding your past history and your present neurological concerns. Please answer all questions carefully and completely, as the information is very important to your care. Please bring this form with you to your first doctor's visit.

DATE: __________

Age: ______

Tel. # Home: __________________ Work:___________________ Cell:______________

List your physicians, including addresses, zip codes and phone numbers. Put a * by your primary physician so that a report of your visit may be sent to him or her.

____
____
____
____
____

Are you naturally: right-handed____ left-handed____ ambidextrous____

****

Have you been diagnosed with Huntington's Disease? Y/N.

If you have <u>NOT</u> been diagnosed, skip to the section on Medical History.

****

Early Symptoms

What were your initial symptoms? Involuntary movements____ Balance problems____ Mood changes____ Cognitive problems____

What year did the symptoms begin?_______ What year were you diagnosed?_______

Have you had genetic testing? Y / N

Huntington's Medication History

For each drug below that you have ever taken, please indicate if it was helpful or of no benefit, and any side effects which may have occurred when you took it. If you have records available, the dosage information is very helpful.

Please complete this checklist if you have ever received or are currently receiving treatment for Huntington's disease.

Drug Name	*Maximum Dose*	*Beneficial? Yes*	*No*	*Side Effects*
Tetrabenazine (Xenazine)	_____	___	___	_____
Amantadine	_____	___	___	_____
Haloperidol (haldol)	_____	___	___	_____
Fluphenazine	_____	___	___	_____
Risperidone (risperdal)	_____	___	___	_____
Olanzapine (zyprexa)	_____	___	___	_____
Aripiprazole (abilify)	_____	___	___	_____
Quetiapine (seroquel)	_____	___	___	_____
Clozapine (clozaril)	_____	___	___	_____
Ziprasidone (geodon)	_____	___	___	_____
Lurasidone (latuda)	_____	___	___	_____
Paliperidone (invega)	_____	___	___	_____

****

Medical History (All patients please complete)

Please list all medical conditions, including date of onset, for which you see a doctor or for which you have seen a doctor in the past (i.e.—high blood pressure, diabetes, cardiac problems, depression).

1._____

2._____

3._____

4._____

5._____

6._____

Operations and Hospitalizations

Please list all operations and hospitalizations starting with the most recent.

Surgery or Hospitalization	*Date*		*Surgery or Hospitalization*	*Date*

Current Medications (including vitamins and supplements)

Medication	*Dosage*	*How Often*

Drug Allergies

Medication	*Allergic Response*

Side Effects of Current Medications (check all that apply)

___Drug doesn't last long enough
___Involuntary movements from drugs
___Sleepiness/drowsiness from medications
___Frequent falls
___Nightmares
___Hallucinations
___Insomnia
___Confusion
___Memory loss
___Depression
___GI upset
___Bowel problems

Any other problems with medications?

_____

_____

_____

Social History

Education Level: _____

Marital Status: S M Sep W D Partnered Occupation:_____

Employed: Y/N Retired: Y/N If yes, at what age?____ Hours worked per week:_____

Where do you live? Own home__ Apartment__ Assisted Living__ Nursing Home__

With whom do you live? Alone__ With spouse__ With family member(s)__ Other__

How is your spouse's health?_____
_____

Do you smoke? Y/N. If yes, cigarettes____ # packs per day____ cigars____ pipe____

Do you drink alcohol? Y/N. If yes, how much?_____

Do you use any other drugs? Y/N. If yes, please list:_____
_____

Family History

Relative	Sex	Age	Health Problems	Age at death	Cause of death
Mother	F				
Father	M				
Siblings					
Siblings					
Siblings					
Children					
Children					
Children					

Any relatives with Huntington's disease or any other neurological illnesses?

_____
_____

Review of Systems

Have you ever experienced any of the following symptoms?

Symptoms	Yes	No		Symptoms	Yes	No
Persistent fevers				Impotence		
Unexplained weight loss				Loss of vision		
Rashes				Double vision		
Joint pain				Hearing loss		
Easy bruising				Ringing in ears		

Blood clots in legs or lungs				Persistent dizziness		
Miscarriage				Difficulty swallowing		
Skin or hair changes				Difficulty talking		
Allergies				Leg or arm weakness		
Sinusitis				Numbness in arms or legs		
Neck pain				Trouble walking		
Low back pain				Head trauma		
Difficulty breathing				Headaches		
Chest pain				Seizures		
Palpitations				Memory loss		
Persistent diarrhea				Trouble sleeping		
Persistent vomiting				Anxiety or depression		
Discolored urine				Tremor		
Bowel or bladder accidents				Balance problems		

Experimental Drug Studies

We always have studies in progress investigating new drugs or new applications for approved medications. Do you have any interest in learning about these studies or possibly participating in a drug evaluation? ____yes ____no

Please include any additional information that you feel may be helpful for us to know:

_____
_____
_____
_____