NEUROLOGICAL HISTORY

ID NUMBER: ☐☐☐☐☐☐☐

FORM CODE: N H X

DATE: 04/01/2016
Version 3.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

0b. Staff ID: ☐☐☐

Instructions: *This questionnaire asks for information on your medical history. Please take your time and answer carefully. Mark only one response for each question or statement. For "multiple choice" and "yes/no" type questions, place an 'X' in the appropriate response box. If you make a mistake, black out that box and place an 'X' in the correct box.*

1. Have you ever been told by a doctor or health professional that you had/have Parkinson's disease?
   - Yes ..... ☐Y
   - No ..... ☐N → **GO TO ITEM 2**
   - Don't know ..... ☐D → **GO TO ITEM 2**

   a. How old were you when you were first told you had Parkinson's disease?

   ☐☐ Age in years

2. Have you ever had a head injury that resulted in loss of consciousness?
   - Yes ..... ☐Y
   - No ..... ☐N → **GO TO ITEM 3**
   - Don't know ..... ☐D → **GO TO ITEM 3**

   a. Have you had a head injury with extended loss consciousness (> 5 min)?
   - Yes ..... ☐Y
   - No ..... ☐N
   - Don't know ..... ☐D

   b. Have you had a head injury that resulted in long-term problems or dysfunction?
   - Yes ..... ☐Y
   - No ..... ☐N
   - Don't know ..... ☐D

3. Have you ever had a seizure or convulsion?
   - Yes ..... ☐Y
   - No ..... ☐N → **GO TO ITEM 4**
   - Don't know ..... ☐D → **GO TO ITEM 4**

   a. How many times? ☐☐

   b. How old were you when this <u>first</u> occurred?

   ☐☐ Age in years

c. How old were you when this last occurred? (*Skip if only 1 occurrence*)

☐☐ Age in years

d. Have you ever been treated with anti-seizure medications?

Yes ..... ☐Y
No..... ☐N→ **GO TO ITEM 4**
Don't know..... ☐D→ **GO TO ITEM 4**

e. How old were you when you started taking anti-seizure medications?

☐☐ Age in years

4. Have you ever been told by a doctor or health professional that you had/have any other neurologic disorders such as:

	No	Yes	If Yes, age at diagnosis
a. Multiple Sclerosis	☐N	☐Y	☐☐
b. Brain tumor	☐N	☐Y	☐☐
c. Dementia, Alzheimer's disease or senility or hardening of the arteries of the brain	☐N	☐Y	☐☐
d. Stroke or cerebrovascular accident	☐N	☐Y	☐☐

5. Have you ever had surgery or radiation therapy involving your skull or brain?

Yes ..... ☐Y
No..... ☐N→ **GO TO ITEM 6**
Don't know..... ☐D→ **GO TO ITEM 6**

a. Surgery

Yes ..... ☐Y
No..... ☐N
Don't know..... ☐D

b. Radiation

Yes ..... ☐Y
No..... ☐N
Don't know..... ☐D

6. Have you ever been diagnosed by a doctor with depression?

Yes ..... ☐Y
No..... ☐N→ **GO TO ITEM 7**
Don't know..... ☐D→ **GO TO ITEM 7**

a. Have you been diagnosed with depression in the past 2 years?

Yes ..... ☐Y
No..... ☐N
Don't know..... ☐D

b. Were you ever diagnosed with depression before that (prior to 2 years ago)?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D

c. Have you ever been treated for depression?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D

7. Have you ever had problems with your memory?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D

8. Without glasses or contact lenses, is your vision normal?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D

9. Do you usually wear glasses or contact lenses?

Yes ..... ☐ Y
No..... ☐ N → **GO TO ITEM 10**
Don't know..... ☐ D → **GO TO ITEM 10**

a. Is your vision normal <u>with</u> glasses or contact lenses?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D

10. Without a hearing aid(s), is your hearing normal?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D

11. Do you usually wear a hearing aid(s)?

Yes ..... ☐ Y
No..... ☐ N → **GO TO ITEM 12**
Don't know..... ☐ D → **GO TO ITEM 12**

a. Is your hearing normal <u>with</u> a hearing aid(s)?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D

12. Are you sleepy most of the day?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D

13. In the past month, how many days did you "doze off" during the day other than taking a regular nap?

☐☐ days per month

14. Have you ever been told, or suspected yourself, that you "act out your dreams" while you sleep, for example, punching or flailing your arms in the air, making running movements, shouting, or screaming?

Yes ..... ☐ Y
No..... ☐ N → **GO TO ITEM 15**
Don't know..... ☐ D → **GO TO ITEM 15**

a. How often?

Less than three times in total ..... ☐ 1
Less than once a month..... ☐ 2
1-3 times a month ..... ☐ 3
Once a week..... ☐ 4
More than once per week..... ☐ 5
Don't know..... ☐ D

b. How old were you, when this started?

☐☐ Age in years

15. Do you have shaking in your hands, arms or legs that you can't control?

Yes ..... ☐ Y
No..... ☐ N → **GO TO ITEM 16**
Don't know..... ☐ D → **GO TO ITEM 16**

a. How old were you, when this first started?

☐☐ Age in years

16. Is your handwriting smaller than it once was?

Yes ..... ☐ Y
No..... ☐ N
Don't know..... ☐ D