

Manitowoc Area Memory Assessment Center
2021 S. Alverno Rd.
Manitowoc, WI 54220

Patient's Name _____

Geriatric Memory Assessment Health History Form

Instructions: To be completed by a family member and brought to the first clinic visit. Please fill in the blanks or circle "yes" or "no".

Past Medical History (include all diagnoses, hospitalizations and operations including year)

Prescription Medications (please list name of medicine, dose and when taken)

Name	Dose	When taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Non-Prescription medications: (examples are aspirin, laxatives, supplements, vitamins, and minerals if used regularly)

Name	Dose	When taken
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Drug and Food Allergies:

Specific Medical History:

Diabetes Mellitus	Yes	No
Thyroid disease	Yes	No
Mental retardation	Yes	No
Closed head injury (with loss of consciousness)	Yes	No
Stroke	Yes	No
High blood pressure	Yes	No
Tuberculosis	Yes	No
Cancer	Yes	No
Heart disease or irregularity	Yes	No
History of electroconvulsive therapy	Yes	No

Family History:

Diabetes Mellitus	Yes	No
Heart Disease	Yes	No
Hypertension	Yes	No
Stroke	Yes	No
Alcoholism	Yes	No
Parkinson's disease	Yes	No
Down's syndrome	Yes	No
Dementia/Alzheimer's Disease	Yes	No
Cancer	Yes	No
Depression	Yes	No
Other psychiatric disorders	Yes	No

Instructions: Please circle "yes" or "no" or "unsure" to indicate that you have had a significant or recent problem with any of the following items.

Review of Symptoms:

Weight gain	Yes	No
Weight loss (amount_____)	Yes	No
Fever, chills, night sweats	Yes	No
Increased drinking or urinating	Yes	No
Dizziness or lightheadedness	Yes	No
Fainting	Yes	No
Headaches	Yes	No
Rashes or skin problems	Yes	No

Easy bruising or bleeding	Yes	No
Fatigue	Yes	No
Falls	Yes	No
<i>Eye, Ear, Nose and Throat</i>		
Cataract	Yes	No
Glaucoma	Yes	No
Blurred or double vision	Yes	No
Ringing in ears	Yes	No
Teeth or gum problems	Yes	No
Hoarseness	Yes	No
<i>Breasts</i>		
Lumps/Cancer	Yes	No
Tenderness	Yes	No
Drainage from nipple	Yes	No
<i>Musculoskeletal</i>		
Neck/Back pain	Yes	No
Other joint pain	Yes	No
Muscle weakness	Yes	No
Leg cramps while walking	Yes	No
Leg cramps at rest/in bed	Yes	No
Broken bones	Yes	No
Problems walking	Yes	No
Ankle swelling	Yes	No

Respiratory

Choking	Yes	No
Coughing	Yes	No
Shortness of breath with activity	Yes	No
Wheezing	Yes	No
Home oxygen use	Yes	No

Cardiovascular

Palpitations	Yes	No
Chest pain	Yes	No
Shortness of breath at rest	Yes	No
Blood clots	Yes	No
Difficulty breathing when lying flat	Yes	No

Gastrointestinal

Abdominal Pain	Yes	No
Nausea or vomiting	Yes	No
Ulcers	Yes	No
Liver disease	Yes	No
Gallbladder disease	Yes	No
Diarrhea	Yes	No
Bowel incontinence	Yes	No
Constipation	Yes	No
Blood in Stool	Yes	No

Genitourinary(both sexes)

Pain or burning with urination	Yes	No
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Difficulty starting or holding urine	Yes	No
Urinary or bladder infections	Yes	No
Kidney stones	Yes	No
Blood in urine	Yes	No
Urinary incontinence	Yes	No
History of sexually transmitted disease	Yes	No

Neuropsychiatric

Numbness or tingling in arms or legs	Yes	No
Seizures	Yes	No
Tremor	Yes	No
Difficulty walking	Yes	No
Difficulty holding things	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Difficulty sleeping	Yes	No

Please Describe Memory Loss or Other Concerns:

When did patient first notice problems? _____

When did family first notice problems? _____

If diagnosis has been made, what was it? _____

Age diagnosis made? _____

Does patient have Advanced Directives? **Yes No**

Name of person completing form _____