THE Portland Clinic®

Department of Neurology

New Patient Memory Form

FIRST NAME: _____ **LAST NAME:** _____

DATE OF BIRTH: _____ **PRIMARY CARE PROVIDER & CLINIC:** _____

PREVIOUS NEUROLOGIST: _____

WHY ARE YOU SEEING A NEUROLOGIST?

QUESTIONS YOU HAVE FOR YOUR NEUROLOGIST:

WHEN DID YOUR MEMORY PROBLEMS START:

WHAT WAS NOTICED AND WHO NOTICED:

WHAT WAS THE LAST GRADE YOU COMPLETED IN SCHOOL?

- ☐ High School or GED
- ☐ Some College
- ☐ Associates Degree
- ☐ Bachelors Degree
- ☐ Masters Degree
- ☐ Professional Degree

DESCRIBE ANY LEARNING DISABILITIES OR STRUGGLES YOU HAD IN SCHOOL?

Neurology Locations
[11005 8/14]

The Portland Clinic - South
6640 SW Redwood Lane
Portland, OR 97224
(503) 620-7358

The Portland Clinic - Downtown
800 SW 13th Ave
Portland, OR 97205
(503) 221-0161

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CAN YOU DO THE FOLLOWING ACTIVITIES:

	can still do with no difficulty	some difficulty due to memory	can no longer do due to memory	never did this activity	cannot do for other reason	date difficulty started
Work						
Drive						
Manage Finances (balance checkbook, pay bills, etc.)						
Chores						
Grocery Shop						
Socialize/converse with friends						
Personal hygiene (shower, getting dressed)						
Taking medications						
Cook or prepare meals						
Eat meals without assistance						

HAVE YOU HAD ANY OF THE FOLLOWING:

	Yes	No
Mood changes		
Personality changes		
Hallucinations		
Trouble sleeping		
Seizures		
Staring spells or episodes of confusion		
Periods of time with excessive alcohol use		

	Yes	No
Trouble walking or falls		
Vision changes		
Tremor		
Using illegal drugs		
Prior head injury		
History of infection in brain (meningitis)		

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PERSONAL HABITS:

Do you drink alcohol? Yes ____ No ____

If yes: Regularly ____ Socially ____

Hard liquor ☐ 1-3 oz per day ____ over 3 oz per day ____

Beer ☐ 1 bottle/can per day ____ 2 bottles/cans per day ____ 3 or more bottles/cans per day ____

Wine ☐ 1-2 glasses per day ____ 3-5 glasses per day ____ more than 5 glasses per day ____

Do you consume more than 5 drinks within a 24 hour period? Yes ____ No ____

How many days in the last 6 months did you consume more than 5 drinks in a 24 hour period? _____

Do you smoke? Yes ____ No ____

Have you smoked in the past? Yes ____ No ____

Do you or have you used recreational / illicit drugs? Yes ____ No ____

If yes, what have you used? _____

_____

When did you last use above substance? _____

Do you drink caffeinated drinks? Yes ____ No ____

If yes, list how many per day of the following: _____ Coffee; _____ Tea; _____ Soda; _____ Energy Drinks

MEDICATION HISTORY

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:
(If you are a Portland Clinic patient and our list is up to date leave blank)

Medication:	Dose:	Frequency:

Please list all allergies and sensitivities (e.g. medications, foods, latex, iodine, etc.)

_____

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PAST MEDICAL HISTORY:

Have you had or do you have any of the following conditions?

	Yes	No		Yes	No
Alcoholism	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Headache	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐
Cancer	☐	☐	Heart Attack	☐	☐
Chest Pain	☐	☐	Jaundice	☐	☐
Colitis	☐	☐	Kidney Disease	☐	☐
Depression / Anxiety	☐	☐	Other Heart Disease	☐	☐
Diabetes	☐	☐	Pain (Chronic	☐	☐
Drug Addiction	☐	☐	Rheumatic Fever	☐	☐
Emphysema	☐	☐	Stomach Ulcers	☐	☐
Frequent Kidney Infections	☐	☐	Thyroid Disease	☐	☐
Frequent Bladder Infections	☐	☐	Trouble Sleeping	☐	☐
Gallbladder disease	☐	☐	Suicidal Thoughts	☐	☐
Gout	☐	☐	Other _____		

SURGERIES:

(List procedure and approximate year)

Procedure	Year	Procedure	Year

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CURRENT SYMPTOMS - IN THE LAST 6 MONTHS: (please mark all that apply)

1. Head, Eyes, Ears, Nose, Throat, Lymph Nodes:

- ___ Headaches
- ___ Double vision
- ___ Hoarseness of voice
- ___ Tinnitus (buzzing or humming)
- ___ Photophobia (light bothers eyes)
- ___ Swollen and/or painful lymph nodes
- ___ Head trauma
- ___ Deafness
- ___ Neck swelling
- ___ Pain and/or drainage from ears
- ___ Nasal and/or sinus congestion
- ___ Visual loss or change
- ___ Nose bleeds
- ___ Neck stiffness
- ___ Sneezing
- ___ Sore throat
- ___ Glaucoma
- ___ Teethe grinding / clenching
- ___ Headaches
- ___ Hearing problems
- ___ Vision problems
- ___ Dental problems
- ___ Sinus problems

2. Respiratory System:

- ___ Shortness of breath
- ___ Sputum/secretion production
- ___ Wheezing
- ___ Cough
- ___ Hemoptysis
- ___ Breathing difficulty

3. Cardiovascular System:

- ___ Chest pain, discomfort, heaviness, tightness
- ___ Shortness of breath with exertion
- ___ PND (waking up short of breath)
- ___ Orthopnea (sleeping on two or more pillows)
- ___ Leg swelling
- ___ High blood pressure
- ___ Palpitations
- ___ Chest pain
- ___ Heartburn

4. Gastrointestinal System:

- ___ Anorexia (poor appetite)
- ___ Nausea and/or vomiting
- ___ Constipation or diarrhea
- ___ Weight loss or gain
- ___ Hematochezia (red blood in bowel movements)
- ___ Melena (black bowel movements)
- ___ Jaundice
- ___ Abdominal pain
- ___ Dysphagia (difficulty swollowing)
- ___ Stomach pain
- ___ Weight change:
  loss _____ lbs , gain_____lbs

5. Genitourinary System:

- ___ Hematuria
- ___ Oliguria (infrequent urination)
- ___ Incontinence
- ___ Heavy menstrual flow
- ___ Polyuria (urination of large volumes of urnie)
- ___ Nocturia (urination at night)
- ___ Frequency (frequent urination)
- ___ Pyuria (cloudy urine)
- ___ Urgency (sensation to urinate)
- ___ Sexual dysfunction
- ___ Symptoms of menopause
- ___ Irregular periods
- ___ PMS
- ___ Bladder problems
- ___ Excessive urination or thirst

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6. Nervous system:

- ___ Weakness/paralysis one side of body
- ___ Urinary and/or fecal incontinence (wet or soil underwear)
- ___ Memory loss, sleep disturbance, mood disorders (anxiety, depression)
- ___ Insomnia
- ___ Daytime sleepiness
- ___ Snoring
- ___ Sleep apnea
- ___ Seizures / shaking
- ___ Numbness
- ___ Loss of consciousness
- ___ Dizziness

7. Musculoskeletal System:

- ___ Joint pain / swelling / redness
- ___ Muscle aches and pains
- ___ Back pain
- ___ Neck pain
- ___ Leg / foot cramps
- ___ Leg restlessness
- ___ Weakness

8. Dermatological System:

- ___ Rash
- ___ Mole changes
- ___ Pigmentation (change in color)
- ___ Breast pain
- ___ Pruritus (itching)
- ___ Breast lumps
- ___ Bleeding or bruising
- ___ Changes in nipples
- ___ Breast lumps / discharge
- ___ Allergic reaction
- ___ Change in skin / hair

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ9)

Over the last two weeks, how often have you been bothered by any of the following problems? (use ✓ to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or you family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

For office coding: 0 + _____ + _____ + _____

= Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take cafre of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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