SYNERGY
Integrative Medical Center

COGNITIVE HEALTH HISTORY

Patient Name _____

Birthdate _____

Date_____

How long have the cognitive symptoms been present?	_____ yrs	
Have the cognitive symptoms been progressive?	Yes ___	No ___
Was the first problem memory?	Yes ___	No ___
Is the main problem memory?	Yes ___	No ___
Problems with calculations/math?	Yes ___	No ___
Problems with organizing?	Yes ___	No ___
Problems with finding words?	Yes ___	No ___
Problems with reading?	Yes ___	No ___
Problems recognizing faces?	Yes ___	No ___
Saying inappropriate things?	Yes ___	No ___
Headaches?	Yes ___	No ___
Flinging arms wildly while sleeping?	Yes ___	No ___
Is there a loss of empathy (concern for others)?	Yes ___	No ___
Stealing items?	Yes ___	No ___
Sleeping later than you used to?	Yes ___	No ___
Loss of sense of smell?	Yes ___	No ___
Visual hallucinations or delusions?	Yes ___	No ___
Tremors (hand or head shaking) at rest?	Yes ___	No ___
Difficulty looking upward?	Yes ___	No ___
Difficulty with balance or walking?	Yes ___	No ___
Sleep < 7 hours/night?	Yes ___	No ___
Sleep apnea?	Yes ___	No ___
History of loss of consciousness?	Yes ___	No ___
History of head trauma?	Yes ___	No ___
History of stoke?	Yes ___	No ___
History of heart attack or angina?	Yes ___	No ___
History of atrial fibrillation?	Yes ___	No ___
Taking warfarin or coumadin?	Yes ___	No ___

Poor dental health?	Yes ___	No ___
Dental amalgams (silver metal fillings)?	Yes ___	No ___
If yes, more than 3?	Yes ___	No ___
Eat tuna, swordfish or shark more than once/week?	Yes ___	No ___
Root canals?	Yes ___	No ___
History of tick bite?	Yes ___	No ___
History of Lyme Disease?	Yes ___	No ___
History of meningitis?	Yes ___	No ___
Taking valium, xanax, sleeping pills or antidepressants?	Yes ___	No ___
Taking a statin drug for cholesterol?	Yes ___	No ___
Known mold exposure?	Yes ___	No ___
History of chronic fatigue or fibromyalgia?	Yes ___	No ___
History of asthma?	Yes ___	No ___
History of nosebleeds:	Yes ___	No ___
History of arthritis?	Yes ___	No ___
Family history of dementia?	Yes ___	No ___
Family history of brain hemorrhage?	Yes ___	No ___
General anesthesia after 40 years old?	Yes ___	No ___
If yes, more than twice?	Yes ___	No ___
Are you taking hormone replacement therapy?	Yes ___	No ___
Are you taking thyroid medicine?	Yes ___	No ___
History of recurrent cold sores on the lips?	Yes ___	No ___
Gluten sensitivity?	Yes ___	No ___
History of leaky gut?	Yes ___	No ___
History of emphysema?	Yes ___	No ___
History of kidney failure?	Yes ___	No ___
History of alcohol seizures or shakes on withdrawal?	Yes ___	No ___
Drink 2 or more alcoholic drinks per day?	Yes ___	No ___
History of cancer?	Yes ___	No ___
History of chronic constipation?	Yes ___	No ___

Women only:

Hysterectomy:	Yes ___	No ___
If yes, before age 45?	Yes ___	No ___

Men only:

History of prostate cancer treatment?	Yes ___	No ___