Neuropsychological Medical History Questionnaire (NMHQ)

(Janer & Nadler, 1995)

The following questions are designed to provide us with information about your medical history, especially as it pertains to your current neurologic and psychiatric health. We are particularly concerned about characteristics or experiences that can affect both your thinking abilities (for example, memory and concentration) and your emotional functioning, so that we can take them into consideration in our assessment.

Please answer the questions honestly and completely. All information will be kept confidential and shared only with your referring doctor or therapist. The neuropsychologist will review the history with you so that you will have a chance to discuss your answers in detail. Thank you for your cooperation.

I. DEMOGRAPHIC INFORMATION

Name: Last:_____ First:_____ M.I.:_____

Date of Birth: Month:_____ Date:_____ Year:_____ Age:_____

Handedness: ____Right ____Left ____Ambidextrous ____Mixed Dominance

Education : _____

Name/Type of highest school attended: _____

Occupation: _____

Most recent job held: _____

Current living situation: ____Live alone ____Live w/ _____
(please indicate relationship)

Medications: Please list below the names and dosages of all your medications.

Medication Name	Dosage (including *how many times* per day you take it & *when* you take it)	Length of time you have been on this med.

Instructions: *Please circle the most accurate response for each of the following questions. If you* ***don't know*** *the information, then circle* ***DK****. If for any question you feel that the best answer would be "****maybe****", then please answer "****Yes****." For any question, if any one particular part of the question applies to you more than the rest, underline that part of the question.*

Name of person completing questionnaire: _____

II. NEURODEVELOPMENTAL HISTORY

The following series of questions refers to when you were a CHILD or an ADOLESCENT.

During her pregnancy with you, did your mother have any of the following medical problems:

Required bedrest or hospitalization for medical problems?	*Yes*	*No*	*DK*
Used alcohol or other non-prescription drugs?	*Yes*	*No*	*DK*
Used prescribed medication other than vitamins?	*Yes*	*No*	*DK*
Smoked cigarettes?	*Yes*	*No*	*DK*
Was exposed to lead, solvents, or other toxic substances?	*Yes*	*No*	*DK*
Had preclampsia (high blood pressure due to pregnancy)?	*Yes*	*No*	*DK*
Suffered a serious physical injury?	*Yes*	*No*	*DK*

During your birth, were there any of the following problems or complications:

Were you born prematurely?	*Yes*	*No*	*DK*
Was the cord wrapped around you at birth?	*Yes*	*No*	*DK*
Were forceps used during your delivery?	*Yes*	*No*	*DK*
Did you suffer from lack of oxygen or other fetal distress?	*Yes*	*No*	*DK*
Did you have low APGAR scores (i.e., poor vital signs at birth)?	*Yes*	*No*	*DK*
Were you treated in an infant Intensive Care Unit after birth?	*Yes*	*No*	*DK*
Were there any other birth complications?	*Yes*	*No*	*DK*

If *Yes*, list: _____

Did you experience any delays in your development as a child, such as:

Walking late (i.e., after one year of age)?	*Yes*	*No*	*DK*
Talking late (i.e., after two years of age)?	*Yes*	*No*	*DK*
Poor coordination compared to other children?	*Yes*	*No*	*DK*
Bedwetting (i.e., after five years of age)?	*Yes*	*No*	*DK*
"Tics" (i.e., involuntary movements or sounds such as grunting)?	*Yes*	*No*	*DK*
Parents considered you a "difficult" baby?	*Yes*	*No*	*DK*

Did you experience any learning disability or other school performance problems, such as:

Were you diagnosed with attention deficit (ADD) or hyperactivity?	Yes	No	DK
Were you diagnosed as having a learning disability?	Yes	No	DK
Were you diagnosed as "retarded" or "developmentally delayed"?	Yes	No	DK
Were you ever placed in an ungraded or special classroom?	Yes	No	
Did you fail any courses in elementary/grammar school?	Yes	No	
If Yes, list:_____			
Did you repeat any grades in elementary/grammar school?	Yes	No	
If Yes, list:_____			
Did you fail any courses in high school?	Yes	No	
If Yes, list:_____			
Did you repeat any grades in high school?	Yes	No	
If Yes, list:_____			
Did you receive any resource help, special education, or tutoring?	Yes	No	
Did you receive speech therapy or physical therapy?	Yes	No	

Did your teachers or parents (or other close relative) describe you as someone who:

Couldn't concentrate, or couldn't pay attention for long?	Yes	No
Couldn't sit still, was restless or hyperactive?	Yes	No
Was fidgety?	Yes	No
Daydreamed or got lost in your thoughts?	Yes	No
Had difficulty following directions?	Yes	No
Talked out of turn?	Yes	No
Did messy work?	Yes	No
Failed to finish things you started?	Yes	No
Was inattentive or easily distracted?	Yes	No
Talked too much?	Yes	No
Failed to carry out assigned tasks?	Yes	No
Was easily angered, had frequent temper tantrums or rages?	Yes	No

Compared to the other children, did you have more trouble with the following things:

Problems with physical coordination?	Yes	No
Clumsiness or trouble executing skilled movements?	Yes	No
Difficulties with eye-hand coordination?	Yes	No
Trouble understanding mathematics, geometry, or algebra?	Yes	No
Exceptionally poor with artistic skills (e.g., drawing or painting)?	Yes	No
Difficulties understanding spatial relationships or problems putting things together (e.g., puzzles)?	Yes	No
Trouble following travel directions or problems getting lost or confused when trying to find your way around places?	Yes	No
Shy and withdrawn from your peers?	Yes	No
"Socially awkward" or feeling uncomfortable around others?	Yes	No
Difficulty making friends or a tendency to be socially isolated?	Yes	No
Trouble understanding or interpreting the feelings or emotions of others?	Yes	No
Difficulty communicating your feelings/emotions to others?	Yes	No

III. GENERAL MEDICAL HISTORY

Have you ever had any of the following medical problems:

Childhood diseases or injuries?	*Yes*	*No*	*DK*
High or prolonged fevers or seizures?	*Yes*	*No*	
Serious infections?	*Yes*	*No*	
Thyroid disease or other endocrine (gland) disorder?	*Yes*	*No*	
Diabetes?	*Yes*	*No*	
Liver disease (such as, Hepatitis, Cirrhosis, or Jaundice)?	*Yes*	*No*	
Kidney problems?	*Yes*	*No*	
Hypertension (i.e., high blood pressure)?	*Yes*	*No*	
Heart attack, heart failure, or other heart disease?	*Yes*	*No*	
Problems with arteries or other vascular circulatory disease?	*Yes*	*No*	
Cancer?	*Yes*	*No*	
Gastointestinal bleeding (ulcers, etc.)?	*Yes*	*No*	
Vitamin deficiency?	*Yes*	*No*	
Blood problems?	*Yes*	*No*	
Surgery?	*Yes*	*No*	

If *Yes*, list:_____

Other serious medical problem?	*Yes*	*No*

If *Yes*, list:_____

The folllowing experiences are sometimes related to risk for HIV/AIDS. Please indicate if you have:

Tested positive for HIV?	*Yes* / *No* / *I have never been tested.*		
Had a blood transfusion or operation since 1980?	*Yes*	*No*	
Shared hypodermic needles since 1980?	*Yes*	*No*	
Had sexual contact with a homosexual or bisexual male partner?	*Yes*	*No*	
Had sexual contact with an intravenous drug user?	*Yes*	*No*	

IV. NEUROLOGIC HISTORY

Have you had any of the following neurologic problems:

Head injury **with** or **without** loss of **consciousness** or **confusion**? *Yes* *No* *DK*
(circle one) (circle one)

If *Yes*, how long were you unconscious: _____

Epilepsy or other forms of seizures?	*Yes*	*No*
Periods of disorientation (i.e., not knowing where you are, or not knowing the approximate time, year, or date)?	*Yes*	*No*
Stroke, TIA, aneurysm, brain hemorrhage, or other cerebrovascular problems?	*Yes*	*No*
High fever, meningitis, encephalitis, or other brain infection?	*Yes*	*No*
Fainting or dizzy spells?	*Yes*	*No*
Brain tumor or brain cancer?	*Yes*	*No*
Loss of oxygen from choking, drowning, or suffocation?	*Yes*	*No*
Drug or alcohol overdose?	*Yes*	*No*
Exposure to toxic substances (such as lead, mercury, solvents)?	*Yes*	*No*
Syphilis or other venereal disease?	*Yes*	*No*
Severe or persistent headache, or migraine?	*Yes*	*No*
Parkinson's disease or other movement disorder?	*Yes*	*No*
Alzheimer's disease or other dementia?	*Yes*	*No*
Multiple Sclerosis (MS)?	*Yes*	*No*
Other neurologic disease or damage?	*Yes*	*No*

If *Yes*, list: _____

V. PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Have you ever been evaluated or had treatment for "emotional", mental health, or psychiatric problems such as:

The diagnosis or condition of:

depression or "Seasonal Affective Disorder" (SAD)	*Yes*	*No*
bipolar ("manic-depressive") disorder	*Yes*	*No*
anxiety, panic disorder, or phobia	*Yes*	*No*
obsessive-compulsive disorder (or "OCD")	*Yes*	*No*
schizophrenia or other "thought disorder"	*Yes*	*No*
eating disorder ("anorexia" or "bulimia")	*Yes*	*No*
alcohol abuse or alcoholism	*Yes*	*No*
drug abuse or drug addiction (chemical dependence)	*Yes*	*No*
Other conditions / I'm not sure of the problem	*Yes*	*No*

If *Yes*, list:_____

Have you:

Ever been treated by a psychiatrist, psychologist, or therapist?	*Yes*	*No*
Ever been hospitilization for "emotional" or psychiatric problems?	*Yes*	*No*
Ever taken medication for "emotional" or psychiatric problems?	*Yes*	*No*
Ever been treated by electroconvulsive (ECT) or "shock" therapy?	*Yes*	*No*
Ever had brain surgery for "emotional" or psychiatric problems?	*Yes*	*No*

Please answer the following questions about your use of alcohol:

Do you drink alcoholic beverages regularly now? Yes No
Did you drink alcoholic beverages regularly in the past? Yes No
Do near relatives ever worry or complain about your drinking? Yes No
Do you ever feel guilty about your drinking? Yes No
Do your friends and relatives think that you are a normal drinker? Yes No
Are you able to stop drinking when you want to? Yes No
Have you ever attended a meeting of Alcoholics Anonymous? Yes No
Has drinking ever created a problem between you and a relative or friend? Yes No
Have you ever gotten into trouble at work because of drinking? Yes No
Have you ever neglected family, work, or other obligations because you were drinking? Yes No
Have you ever been in a hospital because of drinking? Yes No
Have you ever been arrested for drunken behavior, drunken driving, or driving while intoxicated? Yes No
Have you ever been arrested, even for just a few hours, because of others' drunken or intoxicated behavior? Yes No
Please indicate how much and how often you drink alcohol over the course of a typical week:_____

_____

Please answer the following questions about your use of drugs:

Have you ever used any non-prescription (recreational) drugs? Yes No
Please indicate the types of drugs you have used & the last time you used each:
Barbiturates or "downers" (e.g., Seconal, Quaaludes, etc.)? Yes No
Last use:_____
Amphetamines or "uppers" (e.g., Dexedrine, meth)? Yes No
Last use:_____
Cocaine or "crack" cocaine? Yes No
Last use:_____
Marijuana or hashish? Yes No
Last use:_____
Opiates (e.g., heroin, methadone, Demerol, "smack")? Yes No
Last use:_____
Hallucinogens (e.g., LSD or "acid"; PCP or "angel dust")? Yes No
Last use:_____

VI. FAMILY HISTORY

Please indicate your parents approximate educations (circle one for each parent):

Mother	< 6 years	grammar school	high school	vocational school	college
Father	< 6 years	grammar school	high school	vocational school	college

Has anyone IN YOUR FAMILY had any of the following medical problems:

Heart attack, heart failure, or coronary artery disease?	*Yes*	*No*	*DK*
Hypertension (high blood pressure)?	*Yes*	*No*	*DK*
Liver disease, hepatitis, cirrhosis, or jaundice?	*Yes*	*No*	*DK*
Kidney disease or dialysis?	*Yes*	*No*	*DK*
Diabetes?	*Yes*	*No*	*DK*
Thyroid disease or other endocrine (gland) disorder?	*Yes*	*No*	*DK*
Vitamin deficiency?	*Yes*	*No*	
Cancer?	*Yes*	*No*	*DK*
Other serious medical problems?	*Yes*	*No*	*DK*

If *Yes*, list:_____

Has anyone IN YOUR FAMILY had any of these neurologic conditions?

Seizures, epilepsy, or "fits"?	*Yes*	*No*	*DK*
Fainting or dizzy spells?	*Yes*	*No*	*DK*
Stroke, brain hemorrhage, TIA, or other vascular problems?	*Yes*	*No*	*DK*
Brain tumor or brain cancer?	*Yes*	*No*	*DK*
Syphilis or other veneral disease?	*Yes*	*No*	*DK*
Severe or persistent headache or migraine?	*Yes*	*No*	*DK*
Parkinson's disease or other movement disorder?	*Yes*	*No*	*DK*
Alzheimer's disease or other dementia?	*Yes*	*No*	*DK*
Multiple sclerosis (MS)?	*Yes*	*No*	*DK*
Other neurologic disease or damage?	*Yes*	*No*	*DK*

If *Yes*, list:_____

Has anyone IN YOUR FAMILY been diagnosed or had treatment for the following developmental, mental health, or psychiatric problems, such as:

Developmental disability or learning disability?	*Yes*	*No*	*DK*
Mental retardation or other intellectual impairment?	*Yes*	*No*	*DK*
Attention deficit disorder (ADD) and/or hyperactivity?	*Yes*	*No*	*DK*
Formal diagnosis of "emotional", mental health, or psychiatric problems?			
Such as:			
depression or "Seasonal Affective Disorder" (SAD)	*Yes*	*No*	*DK*
bipolar ("manic-depressive") disorder	*Yes*	*No*	*DK*
anxiety, panic disorder, phobias	*Yes*	*No*	*DK*
obsessive-compulsive disorder (or "OCD")	*Yes*	*No*	*DK*
schizophrenia or other "thought disorder"	*Yes*	*No*	*DK*
eating disorder ("anorexia" or "bulimia")	*Yes*	*No*	*DK*
alcohol abuse or alcoholism	*Yes*	*No*	*DK*
drug abuse or drug addiction (chemical dependence)	*Yes*	*No*	*DK*
Other condition / I'm not sure of the problem	*Yes*	*No*	*DK*

If *Yes*, list:_____

Has anyone in your family:

Ever been treated by a psychiatrist, psychologist, or therapist?	*Yes*	*No*	*DK*
Ever been hospitilization for "emotional" or psychiatric problems?	*Yes*	*No*	*DK*
Ever taken medication for "emotional" or psychiatric problems?	*Yes*	*No*	*DK*
Ever been treated by electroconvulsive (ECT) or "shock" therapy?	*Yes*	*No*	*DK*
Ever had brain surgery for "emotional" or psychiatric problems?	*Yes*	*No*	*DK*