

Center for Neurocognitive Disorders
1941 East Rd, Ste 4358
Houston, TX 77054
(713) 486-0500



Dear Sir/Madam:

Thank you for choosing the Center of Neurocognitive Disorders for your healthcare needs. We at UTHealth, and its affiliates (Memorial Hermann Hospital and the Mischer Neuroscience Institute), work to provide excellent, cutting-edge patient care, research, and teach the next generation of physicians. We look forward to working with you.

Sincerely,

A handwritten signature in black ink that reads "Paul Schulz".

Paul E. Schulz, MD
Professor and Vice Chair of Neurology for Quality Assurance
Director, Memory Disorders and Dementia Clinics
The University of Texas Health Science Center at Houston
The Mischer Neuroscience Institute and Memorial Hermann Hospital

A. EDUCATION

One of our missions is to train future medical personnel, as a result our physicians may have medical trainees, such as medical students and residents, accompany them during clinic hours. Thank you for allowing them to see you during the appointment, as you greatly assists the training of the next generation's experts.

B. CONSULTING

Our evaluation process will usually require multiple visits. We are setup with a consulting model as opposed to long term care. Our initial visit will be used to establish the patient's main concern and order the proper testing. We may use one of several diagnostic tools, such as Brain MRIs, blood work, neuropsychological testing, and PET scans. After receiving the results of the initial tests, we will schedule a follow up appointment to finalize our assessment and recommend a treatment plan. We ask that all of our patients are accompanied by a family member or anyone else who can help provide us with any additional information about the patient's chief complaint.

Please keep in mind that we are typically a consulting service. Upon completion of the diagnostic process and formulation of a treatment, we will inform your referring physician of our plan, so they can continue your care. If you do not have a referring physician, we are more than happy to help you find one with whom you are comfortable.

C. PRESCRIPTION REFILLS

Upon formulation of the treatment plan, we will prescribe the appropriate medications with more than enough refills to last you until your next appointment. Please do not lose your prescriptions as it is very difficult for us to provide another copy. We typically do not prescribe refills without seeing you. Upon completion of your consultation with us, it will be the referring physician's responsibility to refill your prescriptions. We will communicate with the physician's office directly to inform them of the medications.

D. RESEARCH

To provide our patients the best possible care, we are continually collaborating with experts from around the world to improve the diagnoses, treatment, and prevention of cognitive disorders. This is only possible with the support of our patients, which can include something as simple as answering brief questionnaires or giving blood samples for analysis, or something more complex like a multi-year trial. Our physicians and research coordinators are happy to fully address any concerns you might have about participation in research.

E. COMMUNICATION

The UT Physicians call center will call you to set up an appointment time for your initial visit. It will be difficult to reach our office as our staff spends most of their time assisting patients in person, providing them with instructions, writing orders, filling prescriptions, and scheduling tests. During this time, it is difficult to receive phone calls out of respect for your time and attention. For this reason, please pay careful attention to the instructions provided to you during our appointment time.

We kindly request that calls to the office be kept to a minimum. Medical questions can be saved for a future appointment or emergencies should be directed to the referring physician immediately. Given we are a busy consulting service, constantly evaluating new patients, we may not be able to address your concern over the phone. Symptoms can be discussed in person at your next appointment. If you are experiencing a medical emergency, please go to the Emergency Department.

F. Patient Questionnaire

PATIENT CONTACT INFORMATION	
Full Name:	Date of Birth:
Home Address:	
Home Phone:	Cell Phone:
Email Address:	Fax:
Gender:	Race:
Insurance Related Information:	
Reason for Visit:	
FAMILY MEMBER/CAREGIVER CONTACT INFORMATION	
Full Name:	Relationship to Patient:
Home Address:	
Work Address:	
Work Phone:	Cell Phone:
Email Address:	Fax:
REFERRING MD	
Full Name:	
Address:	
Phone Number:	Fax:

PATIENT HEALTH INFORMATION			
MEMORY	Memory Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Transient Memory Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sustained Memory Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Impaired Long-Term Memory	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Impaired Short-Term Memory	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Impaired Memory of Past Events	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Inability to Form New Memories	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Impaired Learning Ability	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Percentage of Recall Daily Activities	%	
	Cannot Recall Phone Numbers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Confusion Recalling Names	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Asks the Same Question Repeatedly	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Performing Familiar Tasks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Awareness of Memory Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No

LANGUAGE	Reduced General Fund of Knowledge	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Finding Desired Words	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Frequency	<input type="checkbox"/> Every sentence <input type="checkbox"/> Few times per day <input type="checkbox"/> Once per week	
VISUOSPATIAL	Difficulty Understanding Others as They Speak	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Writing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Reading	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulties Getting Lost	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Confused in Finding Someplace	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Lost in Unfamiliar Areas	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ORIENTATION	Lost in Familiar Neighborhoods	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Gets Lost Finding Particular Room in Your House	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulties Recalling:	<input type="checkbox"/> Day of the week <input type="checkbox"/> Date in month <input type="checkbox"/> Month <input type="checkbox"/> Year	
	Difficulties Recalling Location	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ATTENTION	Difficulties Recalling Names	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulties Maintaining Attention on a Task as Compared to Past	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Following a Television Show	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CALCULATIONS	Do Paragraphs Have to be Re-read	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Unable to Balance Checkbook	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have problems balancing your own checkbook?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Unable to Give Correct Dollars When Paying Grocers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Unable to Calculate Tip at a Restaurant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ACTIVITIES OF DAILY LIVING (ADLs)	Unable to Cook as Well as in the Past	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Complexity of Meals	1 2 3 4 5 6 7 8 9 10	
	Difficulty Feeding Oneself	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Picking Out Own Clothes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Unable to Use the Remote Control for TV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Unable to Load and Use a Dishwasher	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Unable to Manage One's Own Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Changes in Hobby Involvement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Unable to Drive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Not Driving in the City	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Recent Accidents	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Grooming	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulty Bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MOOD/AFFECT	Difficulty Dressing Oneself	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Unable to Use The Telephone By Oneself	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Unable to Use a Vacuum Cleaner	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Unable to Do One's Own Shopping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Unable to Do One's Own Housekeeping Work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Depressed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Anxious	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Recent Change in Weight Weight Gain lbs Weight Loss lbs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Change in Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Change in Sleep Patterns	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Change in Interest in Sexual Activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	PERSONALITY	Feelings of Sadness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thoughts About Suicide		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Change in Personality		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Decreased Tolerance for Frustration		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
BEHAVIORAL	Patient Less Bothered by Things Going on Around You	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Change in Behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Off-Color Joking or Suggestive Comments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Stereotyping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Spent or Invested Money in an Atypical Way	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Change in Judgment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Any Agitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Demonstrated Aggressive Actions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	HALLUCINATIONS/ DELUSIONS/ ILLUSIONS	Auditory Hallucination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Visual Hallucination	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Description of Hallucination				
Friendly Hallucinations		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Frightening Hallucinations		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hearing Things Different Than Normal		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Seeing Things Different Than Normal		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Concerned About People Taking Things		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Illusion		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
VASCULAR SYMPTOMS		Previously diagnosed with Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No

	Which side of your body, if any, was involved?	<input type="checkbox"/> N/A	<input type="checkbox"/> Right	<input type="checkbox"/> Left
	Stroke symptoms that have worried you about the possibility of a stroke		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Taking medications to prevent stroke		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Long-lasting episodes of weakness on one side of your body?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Long-lasting episodes of numbness		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Loss of Vision		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Seeing Double		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Problems Feeling One Side of Face		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulties Speaking		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulties Swallowing		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Problems Hearing or Localized Sounds		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Problems with Balance		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Problems with Vertigo		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Problems with Dizziness		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Heart Attack		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Irregular Heart Beat		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hypertension		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Elevated Cholesterol or Triglycerides		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Diabetes Mellitus		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Peripheral Vascular Disease			
STRENGTH	Decreasing Muscle Mass		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Muscles Jumping		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Muscle Weakness		<input type="checkbox"/> Yes	<input type="checkbox"/> No
EXTRAPYRAMIDAL	Change in Walking		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Walking Changed		Date:	
	Difficulty with Balance		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Arthritis Impacting Walking		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Falls While Walking		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Developed Tremors		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Neck Stiffness		<input type="checkbox"/> Yes	<input type="checkbox"/> No
WORK-UP	Have you had an MRI of your brain or spinal cord? Please bring a CD of any imaging with you to our appointment.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Date:	Location:		
	Have you had neuropsychological testing? If so, please bring those results to our appointment.		<input type="checkbox"/> Yes	<input type="checkbox"/> No

TREATMENTS

Have you had blood-work to evaluate your thinking difficulties? If so, please bring copies of the results to our appointment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had an electroencephalogram (an EEG)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a SPECT scan or a PET scan? If so, please bring the results and the images on a CD to our meeting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a spinal tap (a lumbar puncture)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any treatments for your thinking difficulties? This might have included things like donepezil (Aricept), rivastigmine (Exelon), galantamine (Reminyl), memantine (Namenda), Tacrine (Cognex), Vitamin E, Vitamin C, etc...	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any medications for your mood, such as antidepressants or anti-anxiety medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PAST MEDICAL HISTORY

List any medical problems or conditions you have currently or in the past:

Have you been diagnosed with or been treated for any of the following?

Hypertension

Diabetes

Obesity

Tobacco use

Alcoholism

Stroke

Heart attacks

SURGERIES		
Type:	Date:	Hospital:

REVIEW OF SYSTEMS		
Constitutional		
<input type="checkbox"/> Recent Weight Gain	<input type="checkbox"/> Feeling Poorly	<input type="checkbox"/> Fever
<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tired (fatigue)	<input type="checkbox"/> Chills
Eyes		
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Drooping Eyelids	<input type="checkbox"/> Blurry Vision
<input type="checkbox"/> Red Eyes	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eyesight Problems
<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Discharge from Eyes
Ear, Nose, and Throat (ENT)		
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Earache	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Hoarseness
	<input type="checkbox"/> Tinnitus	
Cardiovascular		
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Fast Heart Rate	<input type="checkbox"/> Leg Pain
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Slow Heart Rate	<input type="checkbox"/> Lower Leg Swelling
Respiratory		
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Short Breath Lying Down
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of Breath on Exertion	<input type="checkbox"/> Paroxysmal Nocturnal Dyspnea (PND)
Sleep		
<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Snoring	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Apnea		
Gastrointestinal		
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Black or Tarry Stools
<input type="checkbox"/> Nausea	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Bowel Incontinence
Genitourinary – Female		
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Urinary Incontinence	<input type="checkbox"/> Painful Menstruation	<input type="checkbox"/> Abnormal Vaginal Bleeding
<input type="checkbox"/> Urgency	<input type="checkbox"/> Frequency	<input type="checkbox"/> Lack of Sex Drive
Genitourinary – Male		
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Hesitancy	<input type="checkbox"/> Genital Lesion
<input type="checkbox"/> Urinary Incontinence	<input type="checkbox"/> Nighttime Urination	<input type="checkbox"/> Testicular Pain
<input type="checkbox"/> Urgency	<input type="checkbox"/> Frequency	<input type="checkbox"/> Lack of Sex Drive
<input type="checkbox"/> Impotence		
Musculoskeletal		
<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Joint Stiffness
<input type="checkbox"/> Limb Pain	<input type="checkbox"/> Limb Swelling	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Muscle Cramps
Integumentary		

<input type="checkbox"/> Skin Lesions	<input type="checkbox"/> Itching	<input type="checkbox"/> Dry Skin
<input type="checkbox"/> Skin Wound	<input type="checkbox"/> Change in a Mole	<input type="checkbox"/> An Unusual Growth
Neurological/Cognitive		
<input type="checkbox"/> Confused or Disoriented	<input type="checkbox"/> Decreased Concentrating Ability	<input type="checkbox"/> Changed Thought Patterns
<input type="checkbox"/> Memory Lapses/Loss	<input type="checkbox"/> Difficulties in Speech	<input type="checkbox"/> Repeating Questions
<input type="checkbox"/> Exag/Inapp Emotional Outburst		
Motor		
<input type="checkbox"/> Facial Weakness	<input type="checkbox"/> Arm Weakness	<input type="checkbox"/> Hand Weakness
<input type="checkbox"/> Leg Weakness	<input type="checkbox"/> Poor Coordination	<input type="checkbox"/> Difficulty Writing
<input type="checkbox"/> Tremor		
Sensory		
<input type="checkbox"/> No Sensation	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling
<input type="checkbox"/> Burning Sensation	<input type="checkbox"/> Hyperesthesia	
General		
<input type="checkbox"/> Seizures	<input type="checkbox"/> Cluster Headache	<input type="checkbox"/> Fainting
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Lightheadedness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Tension Headache	<input type="checkbox"/> General Headache
Gait		
<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Inability to Walk	<input type="checkbox"/> Ataxia
<input type="checkbox"/> Frequent Falls	<input type="checkbox"/> Limping	
Psychiatric		
<input type="checkbox"/> Suicidal	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Change in Personality
<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Depression	<input type="checkbox"/> Emotional Problems
Endocrine		
<input type="checkbox"/> Protruding Eyes	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Feelings of Weakness
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Deepening of the Voice	
Heme/Lymph		
<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Swollen Glands in the Neck
<input type="checkbox"/> Easy Bruising		

SOCIAL HISTORY

Date of Birth:			
Birthplace:			
Marital Status:			
Do you live with your spouse?	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Highest Education Level:			
Are you working?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Occupation:			
Did you retire?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Handedness:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	

Habits:		
Alcohol Use		
<input type="checkbox"/> None	<input type="checkbox"/> Up to 2 drinks per day	<input type="checkbox"/> More than 2 drinks per day
Did you ever have a problem with drinking too much?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, Pipe, or Cigar Use		
<input type="checkbox"/> Never Smoked	<input type="checkbox"/> Current Smoker	<input type="checkbox"/> Previous Smoker
<input type="checkbox"/> Recreational Drug Use		
Did you ever use illicit drugs, such as marijuana, cocaine, heroin, etc...?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Drug:	When:	How much:
<input type="checkbox"/> Never Used	<input type="checkbox"/> Current User	<input type="checkbox"/> Previous User

FAMILY HISTORY				
Please check if you have a family history of:				
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Stroke		
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Parkinson's disease		
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Weakness		
Please indicate whether your relatives are alive or deceased, what illnesses they have or had, and the disease from which they might have died. If anyone in your family had neurologic difficulties or any problems with thinking or memory, please list the persons and their difficulties.				
Relative:	Name:	Status of Life:	Neurologic Illnesses	Other Illnesses:
Maternal Grandmother		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s): Age of Onset:
Maternal Grandfather		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:
Paternal Grandmother		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:
Paternal Grandfather		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:

Mother		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Father		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Aunts:		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Uncles:		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	

		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Siblings:		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset::	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	List and Age of Onset:	
		<input type="checkbox"/> Alive Age::	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Children:		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased	Type(s) and Age	

		Age:	Age at Death: Cause of Death:	of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset::	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
Grandchildren:		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	

		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	
		<input type="checkbox"/> Alive Age:	<input type="checkbox"/> Deceased Age at Death: Cause of Death:	Type(s) and Age of Onset:	