



NEUROLOGICAL HISTORY



ID NUMBER:

FORM CODE:

DATE: 04/01/2016
Version 3.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /
Month Day Year

0b. Staff ID:

Instructions: This questionnaire asks for information on your medical history. Please take your time and answer carefully. Mark only one response for each question or statement. For "multiple choice" and "yes/no" type questions, place an 'X' in the appropriate response box. If you make a mistake, black out that box and place an 'X' in the correct box.

1. Have you ever been told by a doctor or health professional that you had/have Parkinson's disease?

Yes Y
 No N → **GO TO ITEM 2**
 Don't know D → **GO TO ITEM 2**

a. How old were you when you were first told you had Parkinson's disease?

Age in years

2. Have you ever had a head injury that resulted in loss of consciousness?

Yes Y
 No N → **GO TO ITEM 3**
 Don't know D → **GO TO ITEM 3**

a. Have you had a head injury with extended loss consciousness (> 5 min)?

Yes Y
 No N
 Don't know D

b. Have you had a head injury that resulted in long-term problems or dysfunction?

Yes Y
 No N
 Don't know D

3. Have you ever had a seizure or convulsion?

Yes Y
 No N → **GO TO ITEM 4**
 Don't know D → **GO TO ITEM 4**

a. How many times?

b. How old were you when this first occurred?

Age in years

c. How old were you when this last occurred? (Skip if only 1 occurrence)

Age in years

d. Have you ever been treated with anti-seizure medications?

Yes _Y
No _N → **GO TO ITEM 4**
Don't know _D → **GO TO ITEM 4**

e. How old were you when you started taking anti-seizure medications?

Age in years

4. Have you ever been told by a doctor or health professional that you had/have any other neurologic disorders such as:

	No	Yes	If Yes, age at diagnosis
a. Multiple Sclerosis.....	<input type="checkbox"/> _N	<input type="checkbox"/> _Y	<input type="text"/> <input type="text"/>
b. Brain tumor.....	<input type="checkbox"/> _N	<input type="checkbox"/> _Y	<input type="text"/> <input type="text"/>
c. Dementia, Alzheimer's disease or senility or..... hardening of the arteries of the brain	<input type="checkbox"/> _N	<input type="checkbox"/> _Y	<input type="text"/> <input type="text"/>
d. Stroke or cerebrovascular accident.....	<input type="checkbox"/> _N	<input type="checkbox"/> _Y	<input type="text"/> <input type="text"/>

5. Have you ever had surgery or radiation therapy involving your skull or brain?

Yes _Y
No _N → **GO TO ITEM 6**
Don't know _D → **GO TO ITEM 6**

a. Surgery

Yes _Y
No _N
Don't know _D

b. Radiation

Yes _Y
No _N
Don't know _D

6. Have you ever been diagnosed by a doctor with depression?

Yes _Y
No _N → **GO TO ITEM 7**
Don't know _D → **GO TO ITEM 7**

a. Have you been diagnosed with depression in the past 2 years?

Yes _Y
No _N
Don't know _D

b. Were you ever diagnosed with depression before that (prior to 2 years ago)?

Yes Y
No..... N
Don't know..... D

c. Have you ever been treated for depression?

Yes Y
No..... N
Don't know..... D

7. Have you ever had problems with your memory?

Yes Y
No..... N
Don't know..... D

8. Without glasses or contact lenses, is your vision normal?

Yes Y
No..... N
Don't know..... D

9. Do you usually wear glasses or contact lenses?

Yes Y
No..... N → **GO TO ITEM 10**
Don't know..... D → **GO TO ITEM 10**

a. Is your vision normal with glasses or contact lenses?

Yes Y
No..... N
Don't know..... D

10. Without a hearing aid(s), is your hearing normal?

Yes Y
No..... N
Don't know..... D

11. Do you usually wear a hearing aid(s)?

Yes Y
No..... N → **GO TO ITEM 12**
Don't know..... D → **GO TO ITEM 12**

a. Is your hearing normal with a hearing aid(s)?

Yes Y
No..... N
Don't know..... D

12. Are you sleepy most of the day?

- Yes Y
- No..... N
- Don't know..... D

13. In the past month, how many days did you "doze off" during the day other than taking a regular nap?

days per month

14. Have you ever been told, or suspected yourself, that you "act out your dreams" while you sleep, for example, punching or flailing your arms in the air, making running movements, shouting, or screaming?

- Yes Y
- No..... N → **GO TO ITEM 15**
- Don't know..... D → **GO TO ITEM 15**

a. How often?

- Less than three times in total 1
- Less than once a month..... 2
- 1-3 times a month 3
- Once a week..... 4
- More than once per week..... 5
- Don't know D

b. How old were you, when this started?

Age in years

15. Do you have shaking in your hands, arms or legs that you can't control?

- Yes Y
- No..... N → **GO TO ITEM 16**
- Don't know..... D → **GO TO ITEM 16**

a. How old were you, when this first started?

Age in years

16. Is your handwriting smaller than it once was?

- Yes Y
- No..... N
- Don't know..... D



INSTRUCTIONS FOR THE NEUROLOGIC HISTORY (NHX) FORM



I. General Instructions

The purpose of this questionnaire is to evaluate whether the subject has been diagnosed with any neurologic disease in the past. This will help us evaluate the type of cognitive impairment or dementia, in individuals with cognitive problems, or might explain some of their testing, in individuals with a previous neurologic diagnosis. If the participant is unable to answer questions, and has a proxy for consent and other history taking, the proxy should be asked these questions about the subject's medical history. If this is the case, the question should be rephrased, such as "Has {S} ever been told by a doctor or health professional that {he/ she} has or had Parkinson's disease?" (with similar adjustments for all questions).

For items that are answered "yes" there are usually follow-up questions to further identify the nature of the diagnosis and history.

II. Detailed Instructions for each Item

- 0a. Enter the date on which the participant was seen in the clinic.
- 0b. Enter the staff ID for the person who completed this form.
- 1. If a participant states that he or she was diagnosed with a "Parkinson's-Plus syndrome" (unlikely in more than a couple of participants, and would include "Progressive Supranuclear Palsy", "Corticobasal degeneration", "Shy-Drager Syndrome" or "Multisystem atrophy"), this would be rated as "yes".
- 1a-2a. Record participant responses. Follow indicated skip patterns.
- 2b. If the participant asks for clarification, the examiner can state that long-term problems or dysfunction refers to problems with memory or symptoms that started at the time of the head injury and lasted for a long period of time after.
- 3-3e. Record participant responses. Follow indicated skip patterns.
- 4a-4c. If the participant states that he or she was told that there might be a diagnosis of any of these conditions, try to establish if a doctor actually gave him or her that diagnosis, or if it was just considered while evaluating another condition, or was considered before a different diagnosis was made. To answer "yes" it should be a diagnosis that was made by a physician or health professional, and was not just entertained as part of a diagnostic workup. Record participant responses. Follow indicated skip patterns.
- 4d. If a participant reports having "TIAs," this should be considered a "NO" response. If a participant reports a "mini stroke," the interviewer should ask, "Was this mini-stroke also called a TIA"?. If the participant says no, or the participant is not sure, the response should be "YES". If the participant says yes, the response should be "NO".
- 5-6c. Record participant responses. Follow indicated skip patterns.

[Items 7 through 13 have been disabled.]

- 14-16. Record participant responses. Follow indicated skip patterns.