Full Name: ______________________, _____________ DOB: __________

MEDICAL HISTORY QUESTIONNAIRE

In the assessment of the presence of attentional or learning problems it is essential to know some of your medical background.

What were the problems that caused you to seek consultation now?

____

____

If applicable:
How did you start investigating whether you have ADD/ADHD?

____

____

By whom were you referred? ____________________________

Current Height and Weight: _____ INCHES; _____ POUNDS
Have you had any recent change in weight? ☐ Yes ☐ No

Do you have any current medical problems?
☐ No, I do not have any active medical problems.

Problem | Recommended Treatment

1. ____
2. ____
3. ____

List all medications and their dosages you are currently taking (include all prescriptions and over-the-counter medications such as antihistamines, decongestants, etc.):

____

____

Have you ever been hospitalized or had surgery?

Problem | Date of Surgery

1. ____
2. ____

Have you ever had a heart problem [high blood pressure, angina, irregular heart beats, heart attack]? ☐ Yes ☐ No If yes, please give details: ________________________________

____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when and what were the results?

____

____________________________, ____________ DOB:

Have you ever had glaucoma [increased pressure in the eye]? ☐ Yes ☐ No
Have you ever had trauma to your eye? ☐ Yes ☐ No
Do you wear corrective lenses? ☐ Yes ☐ No
If so, when was your last eye exam?_____________

Have you ever had seizures? ☐ Yes ☐ No
If yes, give details: ____

If you are seeing a Neurologist, please provide his/her name and address:

____

____

____

Have you ever had trauma to your head that caused a loss of consciousness? ☐ Yes ☐ No

If yes, give details: ____

Have you ever had encephalitis [infection of the brain]? ☐ Yes ☐ No
Have you ever had a tic, unusual movements of your body, or Tourette's Syndrome?
☐ Yes ☐ No

If yes, give details: ____

Are you or either of your parents adopted? ☐ Yes ☐ No
If yes, specify: ____

Please give an estimate of your usual caffeine intake per day.
_____ Cups of coffee/day
_____ Cups of tea/day
_____ Caffeinated colas, Mountain Dew, etc./day

Do you currently smoke? ☐ Yes ☐ No
If yes, how many packs per day? _____ Packs per day for _____ years.

Alcoholic beverages – weekly average consumption.
_____ Beer
_____ Wine
_____ Cocktails

Marijuana – weekly average consumption amount in mg _____
☐ vape ☐ oral
☐ inhale ☐ tincture

Narcotics use: ☐ past ☐ current
Medications _________________________
Diagnosis _________________________

NAME ______________________, ____________ DOB:

Do you snore? ☐ Yes ☐ No (Ask a bed partner to be sure)
If yes, do you:

Snore constantly?	☐ Yes	☐ No
Snore for a minute, then quiet for a minute, then snore, then quiet?	☐ Yes	☐ No
Snore only on your back?	☐ Yes	☐ No
Fall asleep easily during the day?	☐ Yes	☐ No

Are you right-sided, left-sided, or ambidextrous when you:

A. Write	☐ Left	☐ Right	☐ Ambidextrous
B. Throw	☐ Left	☐ Right	☐ Ambidextrous
C. Kick	☐ Left	☐ Right	☐ Ambidextrous
D. Swing a bat or racket	☐ Left	☐ Right	☐ Ambidextrous
E. Sight a camera or bow and arrow	☐ Left	☐ Right	☐ Ambidextrous

Do you know of any allergic reactions you have had to medications? ☐ Yes ☐ No

Medication Reaction [hives, nausea, etc]

1. ____

2. ____

3. ____

Have you had any unusual or idiosyncratic responses to medication?

____

FOR WOMEN:

What birth control method do you rigorously use?______________________

Do you have a history of strong mood changes just before your menstrual period begins?
☐ Yes ☐ No

If yes, are your menstrual cycles ☐ regular or ☐ irregular?

Is the onset of symptoms ☐ abrupt or ☐ gradual?

Is the ending or offset of symptoms ☐ abrupt or ☐ gradual?

ACADEMIC HISTORY

How far did you go in school? ______________________

Were there any grades you had to repeat? ______________________

Were there any subjects that you could not do no matter how hard you tried? ☐ Yes ☐ No

If yes, which ones ? ______________________

Have you ever had formal IQ testing? ☐ Yes ☐ No

If yes, when and do you know your scores?______________________

NAME ________________________, ____________ DOB:

MENTAL HEALTH HISTORY

Have you been evaluated for ADHD/ADD in the past? Yes ☐ No ☐

If yes, When? ____

By whom?____

What was your treatment? ______________________________________

Have you been on stimulant medication in the past? Yes ☐ No ☐

If yes, Which one?____

When?____

If you have taken medication for Attention Deficit Disorder now or at any time in the past, did you have any difficulties with the medication?

____

____

Have you had counseling or psychiatric consultation in the past? ☐ Yes ☐ No

If yes, When? ____

With whom? ____

What did you work on? ____

____

Have you ever been depressed? ☐ Yes ☐ No

If yes, please check symptoms you experience(d):

- ☐ Low energy, motivation
- ☐ Loss of appetite
- ☐ Don't care about anything
- ☐ Sleep disturbance
- ☐ Worry, indecision
- ☐ Crying spells
- ☐ Uncharacteristically irritable
- ☐ Sadness
- ☐ Social withdrawal
- ☐ Poor memory
- ☐ Unable to experience pleasure
- ☐ Hopelessness
- ☐ Other (describe): ____

Is the onset of your depressive symptoms typically ☐ triggered by events? or ☐ "Out of the blue" or for no clear reason?

Is the onset of your depressive symptoms typically ☐ gradual over a period of days to weeks? ☐ sudden, in a matter of seconds?

Looking back on your life, how old were you when you first got depressed? ___________

How long do your periods of depression typically last? ________________

NAME ______________________, ____________ DOB:

Do you recall periods in which you experienced the opposite kind of mood...energetic, positive, productive, decreased need for sleep, the feeling of great well being or that there was nothing you could not do? ☐ Yes ☐ No

If yes, how long did it last? ☐ 1/2-day ☐ 2 days
☐ 1-day ☐ more than 4 days

How often do you have such "high" periods? ____________

Do you have family members with:

☐ Major depression?

If yes, whom? __________________ Do they get any treatment? ____________________

☐ Bipolar Disorder?

If yes, whom? __________________ Do they get any treatment? ____________________

NAME ______________________, ____________ DOB:

1. Do you have persistent worry or anxiety?	☐ Yes	☐ No
2. Do you have thoughts that bother you or make you anxious and that you can't get rid of regardless of how hard you try?	☐ Yes	☐ No
3. Do you have a tendency to keep things extremely clean or to wash your hands very frequently, more than other people you know?	☐ Yes	☐ No
4. Do you check things over and over to excess?	☐ Yes	☐ No
5. Do you have to straighten, order, or tidy things so much that it interferes with other things you want to do?	☐ Yes	☐ No
6. Do you worry excessively about acting or speaking more aggressively than you should	☐ Yes	☐ No
7. Do you have great difficulty discarding things even when they have no practical value	☐ Yes	☐ No
8. Do you find that you count things [ceiling tiles, words, money, etc] when you get anxious or bored?	☐ Yes	☐ No
9. Are you superstitious, have lucky or unlucky numbers, habits, etc.?	☐ Yes	☐ No

Have you ever, at any time in your life, excessively used or abused alcohol and/or drugs?

☐ Yes ☐ No If yes, give details:

What? When?

1. ____

2. ____

3. ____

Do you have any genetic relatives who have had trouble with alcohol and/or drugs?

☐ Yes ☐ No If yes, give details:

If yes, who? ____

Have you ever had a blackout while drinking? ☐ Yes ☐ No

Do you now or have you in the past attended A.A., N.A., or some other 12-Step group?

☐ Yes ☐ No If yes, describe: ____

Is there anything else you think would be important to know about you?

____

____

____

____

____

NAME ______________________, ____________ DOB:

ADHD SCREENING CHECKLIST

(To be completed by the Patient)

This checklist inquires about lifelong behaviors. Answer "Yes" only if the particular trait or behavior has consistently impaired your functioning as long as you can remember. If you have the tendency to say “sometimes”, say “no” instead.

#	Question	YES	NO
1.	For your entire life have you consistently had trouble paying attention to details or made careless errors in your work? (1a)	☐	☐
2.	Have you always had a lifelong difficulty concentrating on tasks which you find boring or uninteresting to you? (1b)	☐	☐
3.	Do you often daydream or not seem to listen when people speak to you directly? (1c)	☐	☐
4.	For your entire life have you consistently had difficulty finishing projects you've started? (Do you have a lot of half-finished projects around the home or office?) (1d)	☐	☐
5.	Do you have difficulty organizing your work or become disorganized if not strictly following a plan or list? (1e)	☐	☐
6.	Do you procrastinate or put off undesirable tasks until the last possible moment? (1f)	☐	☐
7.	Have you always had a tendency to lose things necessary to accomplish your daily activities (For example, do you spend time almost every day searching for keys, tools, checkbook, etc.?) (1g)	☐	☐
8.	Have you always been easily distracted by unimportant sounds and events around you? (1h)	☐	☐
9.	Have you always been forgetful (ex: forget names, assignments, etc.)? (1i)	☐	☐
10.	Have you always had difficulty sitting still or fidgeted excessively (even though you can now consciously control it)? (2a)	☐	☐
11.	Have you always had difficulty staying seated? (e.g. Do you have difficulty sitting through a class, movie or church service?) (2b)	☐	☐
12.	For as long as you can remember, have you been restless (e.g. unconsciously patted your foot, not been able to get comfortable sitting in a chair or lying in bed)? (2c)	☐	☐
13.	For your entire life have you had significant difficulty relaxing or slowing down enough to do leisure activities quietly? (2d)	☐	☐

NAME ______________________, ____________ DOB:

		YES	NO
14.	Have you always been described as "high energy" or "always on the go"? (2e)	☐	☐
15.	Do you find that you talk excessively and/or often lose track of what you're saying in conversations? (2f)	☐	☐
16.	For your entire life have you had a pattern of blurting out the answer before the questions have been completed? (2g)	☐	☐
17.	Have you always been impatient or had difficulty waiting your turn in group situations (e.g., waiting in line at the grocery store or driving in traffic) (2h)	☐	☐
18.	Do you frequently interrupt or intrude on others (e.g.. butt into conversations, games, etc.)? (2i)	☐	☐
19.	Have you always been very sensitive (significantly more sensitive than other other people you know) to rejection, teasing, criticism, and frustration?	☐	☐
20.	Do you have a hot temper for which you have no warning?	☐	☐
21.	Do you have stand-up comedy tendencies or a "wacky/zany" sense of humor?	☐	☐
22.	Do you find that you fall asleep when you sit still or suddenly get drowsy when boring tasks are prolonged?	☐	☐
23.	For as long as you can remember have you had a great deal of difficulty waking up and being fully alert in the morning?	☐	☐
24.	Have you been told that you move about excessively during sleep?	☐	☐
25.	For your entire life have you consistently had trouble "turning off your mind" so you could fall asleep?	☐	☐
26.	Do you "Hyperfocus"? That is, do you have periods of activity during which you are so engrossed or involved in what you are doing that you are undistractable by people or events around you and lose track of the passage of time?	☐	☐

If Yes, in what sort of activities do you Hyperfocus?

- ☐ reading
- ☐ artistic activities
- ☐ computer/Internet
- ☐ games, sports
- ☐ gardening
- ☐ other; ______________________________