Brain Health Center
Eldercare Network of Lincoln County

Personal Health History

Save this form and complete it on your computer, or print it blank and complete it by hand. Please bring the completed form to your appointment.

Participant Information

Name

Date of birth

Today's date

Referred by

Form completed by

- ◯ Participant
- ◯ Someone Else

Relationship to Participant (if someone else)

Health Conditions

Check any that apply to you, now or in the past.

Autoimmune, Inflammatory & Infectious

- ☐ Autoimmune condition (e.g., lupus, RA, MS, Hashimoto's)
- ☐ Chronic inflammatory condition
- ☐ Lyme disease or tick-borne illness
- ☐ Herpes-family viral infection (HSV, EBV, VZV, CMV, HHV-6)
- ☐ Other chronic infection

Health Conditions (continued)

Hormone, Vitamin & Atrophy-Related

- [ ] Thyroid disorder
- [ ] Low testosterone / estrogen / DHEA
- [ ] Vitamin D, B12, or folate deficiency
- [ ] Adrenal or cortisol issue
- [ ] Menopause / andropause-related symptoms

Toxin Exposure

- [ ] Heavy metal exposure (lead, mercury, arsenic, etc.)
- [ ] Mold exposure in home or workplace
- [ ] Significant pesticide / chemical exposure

Gastrointestinal

- [ ] Celiac disease
- [ ] Inflammatory bowel disease (Crohn's / ulcerative colitis)
- [ ] Irritable bowel syndrome
- [ ] “Leaky gut” / chronic digestive issues

Vascular / Cardiometabolic

- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Diabetes or prediabetes
- [ ] Heart disease / atrial fibrillation
- [ ] Stroke or TIA (“mini-stroke”)
- [ ] Current or past smoking

Health Conditions (continued)

Trauma, Mood & Sleep

- ☐ Concussion or head injury (even if long ago)
- ☐ Depression
- ☐ Anxiety
- ☐ History of abuse or significant trauma
- ☐ Sleep apnea or other sleep disorder
- ☐ Chronic insomnia

Other health conditions not listed above

Surgeries & Hospitalizations

List all surgeries and hospital stays, especially any requiring general anesthesia or extended rehabilitation.

Procedure / Reason	Year	Anesthesia?	Rehab?
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Anesthesia? = general anesthesia. Rehab? = extended rehab.

Medications & Supplements

List all current prescriptions and non-prescription supplements in the sections below.

Current Medications

Medication	Dose & Frequency	Since When	Reason / Prescriber

Current Supplements

Supplement	Dose & Frequency	Since When	Reason / Prescriber

Social & Occupational History

Occupational History

Include jobs that may have exposed you to toxins, as well as jobs that were mentally demanding or engaging.

Job Title / Employer	Years	Toxin exposure?	Mentally engaging?
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Lifestyle

Highest level of education

Handedness

Alcohol use (type / amount / frequency)

Tobacco use (past/current, how much)

Recreational drug use (past/current)

Exercise (type & frequency)

Social & Occupational History (continued)

Lifestyle (continued)

Typical diet

Current living situation / caregiver support

Family History

Please include any relatives with dementia or memory/cognitive issues. This information is especially important.

Relative (relation)	Cognitive Dx / Type	Age at Onset	Caregiving Challenges

Relative (relation)	Age at Death	Cause of Death	Notes

Family History (continued)

Other relevant family history

Acknowledgment

Please review your answers for completeness before your visit.

Typed signature (full name)

Date