

HUNTINGTON'S DISEASE SOCIETY of AMERICA CENTER OF EXCELLENCE

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle Int.	Birth Date	Birth Place
Address	City	State M/F	Zip code	Home Phone w/Area Code
Occupation	Work Number	Sex	Marital Status	
Person to contact in case of emergency		Relationship	Address	Phone with Area Code

FAMILY HISTORY		IF LIVING			IF DECEASED	
Relationship	Sex	Age	Diagnosed with HD ?	First symptoms and at what age	Age of Death	Cause of Death
Father						
Mother						
Brother/Sister						
	M/F					
	M/F					
	M/F					
	M/F					
Sons/Daughters						
	M/F					
	M/F					
	M/F					
	M/F					
	M/F					

HD Effected Blood Relatives: Diagnosed (DX) or Symptomatic (S) or Unknown (UNK)
 Uncles _____ Aunts _____ Grandmother _____ Grandfather _____ Great Grandmother _____
 Great Grandfather _____

Do you know of any blood relative that has or had: (circle and give relation/s?)

Stroke _____ Epilepsy _____ Heart Attack _____ Cancer _____ Suicide _____
 Stomach Ulcers _____ Asthma _____ Hay Fever _____ Kidney Disease _____
 High Blood Pressure _____ Bleeding Tendency _____ Nervous Breakdown _____
 Tuberculosis _____ Diabetes _____ Leukemia _____ Arthritis _____
 Goiter _____ Colitis _____ Tardive Dyskensia _____ Parkinson's disease _____

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PERSONAL HABITS (circle one)

YES NO Do you regularly smoke? Cigarettes _____ Pipe _____ Cigars _____ for how many years?_

YES NO Do you usually drink over 6 cups of coffee per day? Caffeine Non-caffeinated

YES NO Do you drink wine / liquor / beer? If so, how much and how often? _____

YES NO Do you use any of the following? (enter how often a week) Marijuana _____ Cocaine _____ Street Drugs _____

YES NO Do you awaken early in the morning without apparent cause? If so, how often a week? _____

MEDICATIONS:

Are you presently taking any medications, even over the counter medications? YES If so, please list: NO

Medication Name	Dose	Times a day	Medication Name	Dose	Times a day

Have you been hospitalized for any reason? YES If so why, where and when? NO

Reason	Where	When

Do you have any allergies to Medication or Other? YES, If so list NO

Substance	When Started	Medication

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To be answered by women only:

YES	NO	Are you still having regular monthly menstrual periods?	
YES	NO	Have you ever had bleeding between your periods?	When?
YES	NO	Do you experience very heavy bleeding with your periods?	When?
YES	NO	Do you feel bloated and irritable during your period?	
YES	NO	Are you now or have you ever taken birth control pills?	When? What?

Have you ever been pregnant? Yes No How many children born alive? _ Miscarriages? _____ Stillbirths? _____

How many premature births? _____ Any complications of Pregnancy? If so, what? _____

Date of last menstrual cycle? _____

To be answered by ALL

Yes	No		
		Do you frequently have severe headaches?	
		Do they cause visual trouble?	Type?
		Do they occur on one side of the head?	Where?
		Do they awaken you at night from sleep?	How often?
		Do they feel like a tight hat band?	
		Do they hurt most in the back of the head and neck?	
		Does aspirin relieve them?	
		Have you ever had...	
		Spells of dizziness?	
		Spells of weakness of arm or leg?	
		Ringing in ears?	
		Nosebleeds?	
		Do you frequently have trouble swallowing?	
		Do you frequently have a sore throat?	
		Convulsions?	How often?
		Double visions?	How long lasting?
		Pains in the ears?	How often?
		Do you frequently have hoarseness?	
		Do you frequently have nausea and vomiting?	
		Do you frequently have bleeding gums?	
		Have you ever had pain in the Stomach which...	
		Occurs 1 to 2 hours after a meal?	
		Is brought on by eating fried, gassy foods?	
		Awakens you at night?	
		Is relieved by antacid medications?	
		Is relieved with milk or eating?	
		Occurs while eating or immediately after?	
		Is relieved by a bowel movement?	
		Loss of appetite?	
		Have you ever had...	
		Pain in calves of legs when walking?	
		Cramps in legs at night?	
		Pain in the big toe?	
		Varicose veins?	
		Phlebitis or inflamed leg veins?	
		Swelling in the ankles?	

Describe briefly your present medical symptoms:
