

Medical History Questionnaire

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| 1. Have you ever lost consciousness for more than 5 minutes? | Yes No |
| 2. Do you have a history of head injury? | Yes No |
| 3. Have you ever suffered a head injury resulting in a hospital stay longer than 24 hrs? | Yes No |
| 4. Have you ever experienced fainting spells or blackouts? | Yes No |
| 5. Have you ever undergone neurological surgery? | Yes No |
| 6. Do you have a history of neurological disorder(s)? | Yes No |
| 7. Do you have a history of epilepsy or seizures? | Yes No |
| 8. Do you have a history of respiratory problems or conditions? | Yes No |
| 9. Do you have a history of respiratory or cardiac arrest or hypoxia (lack of oxygen)? | Yes No |
| 10. Do you have a history of limb injury? | Yes No |
| 11. Do you have a history of congenital or developmental problems? | Yes No |
| 12. Do you have a history of learning disability or educational difficulties? | Yes No |
| 13. Are you able to read, write, and spell without difficulty? | Yes No |
| 14. Do you have any history of cardiovascular disease? | Yes No |
| 15. Do you have any history of hyper- or hypo-tension (high- or low blood pressure)? | Yes No |
| 16. Do you have any history of hyper- or hypo-thyroidism? | Yes No |
| 17. Do you have any sensory impairments (vision and hearing)? | Yes No |
| 18. Do you wear glasses or use corrective lenses or contacts? | Yes No |
| 19. Do you have a history of alcohol, drug, or other substance abuse or dependence? | Yes No |
| 20. Do you consume more three or more alcoholic beverages more than two nights a week? | Yes No |
| 21. Do you use tobacco products? | Yes No |
| 22. Do you have a history of sleep disorder(s)? | Yes No |
| 23. Do you have a history of movement problems or musculoskeletal disorder? | Yes No |

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| 24. Do you have a history of psychological or psychiatric disorder(s)? | Yes No |
| 25. Have you ever received treatment for a psychiatric condition
(i.e therapy or medication)? | Yes No |
| 26. Are you currently prescribed any psychiatric medications? | Yes No |
| 27. Are you currently taking any prescription medications? | Yes No |
| 28. Do you have a history of chronic pain? | Yes No |
| 29. Do you have any history of cardiac or cardiovascular problems? | Yes No |
| 30. Do you have any diagnosed medical conditions or current illness? | Yes No |
| 31. Have you ever been prescribed and used a
long-term medication of any kind? | Yes No |

Medications currently prescribed (and taken) with dosage:

If Yes to any of the previous questions please specify and explain below:
