

NEUROPSYCHOLOGICAL SYMPTOM CHECKLIST (NSC)

NAME: _____ AGE _____

This form is being completed by ___ Patient ___ Relative/Friend ___ Doctor

Are you currently under a doctor's care? ___ Yes ___ No

If yes, what is the doctor's name? _____

What is the doctor treating you for? _____

If no, who is your family doctor? _____

Below is a list of questions about your health and health habits. Please think very carefully and check every problem that applies. If you are not sure what the question means or not sure of your answer, just draw a circle around the question and the doctor will help you with it later. Just be sure to answer every question.

Have you had ...

1. ___ loss of sense of smell
2. ___ Change in sense of smell
3. ___ smell of bad odors
4. ___ loss of sense of taste
5. ___ change in sense of taste
6. ___ bad tastes

Are you ...

7. ___ blind in left eye
8. ___ blind in right eye
9. ___ blind in both eyes

Do you ...

10. ___ wear glasses
11. ___ wear contact lenses

Have you had ...

12. ___ blurred vision
13. ___ double vision
14. ___ loss of vision
15. ___ blank spots in vision
16. ___ flashing lights in vision

Are you ...

17. ___ deaf in left ear
18. ___ deaf in right ear
19. ___ deaf in both ears

Do you ...

20. ___ wear a hearing aid

Have you had ...

21. ___ loss of hearing

DOCTOR'S NOTES

LO, FR, DU, IN, EX, RE

Have you had ...

- 22. ___ ringing in ears
- 23. ___ strange sounds in ears

Have you had ...

- 24. ___ any paralysis
- 25. ___ muscle weakness
- 26. ___ muscle twitching
- 27. ___ muscle spasms
- 28. ___ trouble walking
- 29. ___ coordination problems
- 30. ___ balance problems
- 31. ___ tremors or shakiness
- 32. ___ problems with dropping things

Have you had ...

- 33. ___ numbness
- 34. ___ "tingling" skin
- 35. ___ "pins and needles"
- 36. ___ burning skin
- 37. ___ loss of feeling
- 38. ___ loss of telling hot from cold
- 39. ___ change in skin

Do you have ...

- 40. ___ pain
- 41. ___ headaches

Have you had ...

- 42. ___ black-out spells
- 43. ___ seizures or fits
- 44. ___ fainting spells
- 45. ___ periods where you "lose" time

Do you ...

- 46. ___ get lost often
- 47. ___ forget where you are
- 48. ___ forget time and day
- 49. ___ forget meetings
- 50. ___ have memory problems

Do you ...

- 51. ___ hear unusual sounds
- 52. ___ see unusual things
- 53. ___ have strange feelings

Does it seem that you ...

- 54. ___ can't think as quickly as
before
- 55. ___ find it hard to think clearly
- 56. ___ are more easily distracted
- 57. ___ can't concentrate
- 58. ___ have trouble with "common
sense"

Have you had trouble ...

- 59. ___ using tools
- 60. ___ telling right from left
- 61. ___ getting dressed
- 62. ___ remembering the right word
when talking
- 63. ___ understanding others
- 64. ___ following conversation
- 65. ___ with your speech
- 66. ___ with your reading
- 67. ___ with writing

DOCTOR'S NOTES
LO, FR, DU, IN, EX, RE

Have you had problems with ...

- 68. ___ sadness or depression
- 69. ___ stress, tension, or anxiety
- 70. ___ anger or keeping your temper
- 71. ___ worry or guilt
- 72. ___ change in your attitudes
- 73. ___ loss of interest

Have you had ...

- 74. ___ childhood diseases or injuries
- 75. ___ head injuries
- 76. ___ problems with nerves
- 77. ___ high fevers
- 78. ___ serious infections
- 79. ___ diabetes
- 80. ___ liver problems
- 81. ___ kidney problems
- 82. ___ problems with arteries
- 83. ___ a stroke
- 84. ___ hypertension
- 85. ___ heart problems
- 86. ___ blood problems
- 87. ___ cancer

Have you had ...

- 88. ___ surgery
- If yes, what for _____
- _____

Do you ...

- 89. ___ drink alcohol
- If yes, how much _____

Do you ...

- 90. ___ smoke
- If yes, how much _____
- _____

- 91. ___ Take prescribed over-the-counter medication
- If yes, which ones _____
- _____

- 92. ___ work with chemicals
- If yes, which ones _____
- _____

Are there ...

- 93. ___ any family members with history of serious illness
- If yes, describe _____
- _____

If there are any symptoms or medical problems that you have which have not been asked about on this form please describe

DOCTOR'S NOTES

LO, FR, DU, IN, EX, RE