ReCODE Report™
from MPI Cognition

Name:_____

DOB:_____

Patient History and Questionnaire

Duration of cognitive symptoms	_____years		Dental amalgams (old-fashioned metal fillings)?	☐Yes	☐No
Have these symptoms been progressive?	☐Yes	☐No	More than 3 dental amalgams?	☐Yes	☐No
Was the first problem memory?	☐Yes	☐No	Eat tuna, swordfish, or shark more than 1x/week?	☐Yes	☐No
Is the main problem memory?	☐Yes	☐No	History of tick bite?	☐Yes	☐No
Problems with calculation?	☐Yes	☐No	History of lyme disease?	☐Yes	☐No
Problems with organizing?	☐Yes	☐No	History of meningitis?	☐Yes	☐No
Problems finding words?	☐Yes	☐No	Taking a statin drug?	☐Yes	☐No
Problems with reading?	☐Yes	☐No	Mold exposure?	☐Yes	☐No
Problems with recognizing faces?	☐Yes	☐No	History of chronic fatigue or fibromyalgia?	☐Yes	☐No
Saying inappropriate things?	☐Yes	☐No	History of asthma?	☐Yes	☐No
Headaches?	☐Yes	☐No	History of nosebleeds?	☐Yes	☐No
Loss of empathy?	☐Yes	☐No	History of arthritis?	☐Yes	☐No
Stealing items?	☐Yes	☐No	Taking medicine for diabetes?	☐Yes	☐No
Sleeping later than you used to?	☐Yes	☐No	Family history of dementia?	☐Yes	☐No
Loss of sense of smell?	☐Yes	☐No	Family history of brain hemorrhage?	☐Yes	☐No
Visual hallucinations or delusions?	☐Yes	☐No	General Anesthesia afer 40 y.o.?	☐Yes	☐No
Tremor at rest?	☐Yes	☐No	More the 2x General Anesthesia after 40 y.o.?	☐Yes	☐No
Difficulty looking upward?	☐Yes	☐No	Hysterectomy?	☐Yes	☐No
Difficulty with balance or walking?	☐Yes	☐No	Hysterectomy before age 45?	☐Yes	☐No
Sleep less than 7 hours per night?	☐Yes	☐No	Are you taking hormone replacement therapy?	☐Yes	☐No
Sleep apnes?	☐Yes	☐No	Are you taking Thyroid medication?	☐Yes	☐No
History of loss of consciousness?	☐Yes	☐No	History of recurrent herpes on your lips?	☐Yes	☐No
History of head trauma?	☐Yes	☐No	Gluten sensitivity?	☐Yes	☐No
History of stroke?	☐Yes	☐No	History of leaky gut?	☐Yes	☐No
History of heart attack or angina?	☐Yes	☐No	History of emphysema?	☐Yes	☐No
History of atrial fibrillation?	☐Yes	☐No	History of kidney failure?	☐Yes	☐No
Taking Warfarin or Coumadin?	☐Yes	☐No	History of cancer?	☐Yes	☐No
Poor dentition?	☐Yes	☐No	History of prostate cancer treatment?	☐Yes	☐No
Root canals?	☐Yes	☐No	History of chronic constipation?	☐Yes	☐No

History of alcohol seizures or shakes on withdrawal? ☐Yes ☐No

Alcohol use more than 1.5 drinks per day? ☐Yes ☐No

Sleep disturbances (flinging arms wildly at night)? ☐Yes ☐No

Neuroactive medications such as valium, xanax, sleeping pills, anti-depressants? ☐Yes ☐No

Exposure to antibiotics, statins, griseofulvin, AZT, Acetaminophen, NSAIDS, cocaine, methamphetamine, L-DOPA or alcohol? ☐Yes ☐No