

**Patient Information**

[Empty text box]

Patient Name

[Empty text box]

Date of Birth

[Empty text box]

Age

Male

Female

[Empty text box]

Height

[Empty text box]

Weight

[Empty text box]

Blood Pressure

Right handed

Left handed

**Physician Information**

[Empty text box]

Family Doctor Name

( )

Office Phone

**Who directly referred you to the Mayfield Clinic?**

Family doctor \_\_\_\_\_ Office Phone ( )

Specialty physician \_\_\_\_\_ Office Phone ( )

Other \_\_\_\_\_ Office Phone ( )

**REASON FOR OFFICE VISIT**

**History of Present Illness**

**Describe the symptom(s) that you are experiencing:**

List Symptom(s)

Date Symptom(s) Began

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How would you describe your symptoms since they began?**

Better

Worse

No change

**How did this problem begin? (give details)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What other physicians have treated you for this problem?**

Doctor's Name

Type of Doctor

Month / Year

\_\_\_\_\_  
\_\_\_\_\_

**Please list medications for this illness or injury (use back of form if necessary):**

Prescribing Doctor's Name:

Medication Name

Pharmacy where filled

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diagnostic Tests**

**Check any of the following diagnostic tests you have had for this illness or injury.  
(Please indicate when and where tests were done)**

	<u>When (Mo./Year)</u>	<u>Where</u>
<input type="checkbox"/> MRI scan	___/___	_____
<input type="checkbox"/> MRA scan	___/___	_____
<input type="checkbox"/> CT scan	___/___	_____
<input type="checkbox"/> CT scan/myelogram	___/___	_____
<input type="checkbox"/> Angiogram	___/___	_____
<input type="checkbox"/> Bone scan	___/___	_____
<input type="checkbox"/> Plain X-rays	___/___	_____
<input type="checkbox"/> Other	___/___	_____

**Past Medical History**

**Have you ever had any operations/surgery?**

Yes  No

If yes, please give details:

<u>When</u>	<u>Describe the surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____

**Have you ever been treated for blood clots or excessive bleeding?**

Yes  No

**Have you ever had a blood transfusion?**

Yes  No

**Is there any reason you cannot receive blood or blood products?**

Yes  No

If Yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication History**

**What medications are you taking now for other medical conditions, either prescribed or “over the counter”? Please list:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you taking any blood thinners (such as aspirin, Coumadin or Plavix)?**

Yes  No

If Yes, which one? \_\_\_\_\_

**Allergies**

**Are you allergic to any medications?**

Yes  No

If Yes, which medicine? \_\_\_\_\_

What happened? \_\_\_\_\_

**Do you have any allergies to iodine, contrast dye, shellfish, tape, latex?**

Yes  No

If Yes, which ones? \_\_\_\_\_

What happened? \_\_\_\_\_

**Do you have any other allergies?**

Yes  No

If Yes, what are you allergic to? \_\_\_\_\_

What happens? \_\_\_\_\_

**Review of Systems**

**Do you currently have or have had any of the following problems (if yes, give date began):**

**Yes No**

(Mo./Year)

- Fever, chills, or night sweats, weight loss, weight gain / /
- Headaches / /
- Vision blurring, loss of vision / /
- Hearing, balance problems, dizziness / /
- Problems with the mouth, teeth or gums / /
- Do you wear dentures? / /
- Difficulty swallowing, persistent sore throat, swollen glands / /
- Neck pain, stiffness / /
- Chest pain, palpitations, heart disease / /
- High blood pressure / /
- Diabetes / /
- Hepatitis / /
- Tuberculosis  Active  Inactive / /
- Shortness of breath, chronic cough, asthma / /
- Nausea, vomiting, diarrhea, bright red blood per rectum, dark tarry or sticky stools, changes in bowel or bladder habits / /
- Frequency, urgency, burning with urination, bowel or bladder incontinence or difficulty starting a urine stream / /
- Impotence / /
- Other joint pains, loss of motion, problems with circulation in the arms or legs / /
- Loss of sensation, power, strength any other numbness, tingling / /
- Problems with coordination, walking, history of seizures or passing out / /

**Female Patients:**

- Are you pregnant? If yes, when is your due date? / /
- Have you had your ovaries/uterus surgically removed? If yes, give date / /

**Family History**

**Has anyone in your family had any of the following conditions?** (please explain who & what they had)

- Cancer  Yes  No \_\_\_\_\_
- Heart problems  Yes  No \_\_\_\_\_
- Diabetes  Yes  No \_\_\_\_\_
- Kidney disease  Yes  No \_\_\_\_\_
- Depression/mental problems  Yes  No \_\_\_\_\_
- Alzheimer's/memory loss  Yes  No \_\_\_\_\_
- High blood pressure  Yes  No \_\_\_\_\_
- Stroke/brain tumor/aneurysm  Yes  No \_\_\_\_\_
- Lung problems  Yes  No \_\_\_\_\_
- Parkinson's  Yes  No \_\_\_\_\_
- Multiple sclerosis  Yes  No \_\_\_\_\_
- Other problems  Yes  No \_\_\_\_\_

**Social History**

**Indicate your marital status:**  Single  Married  Widowed  Separated  Divorced

**Do you live alone?**  Yes  No

**If married, does your spouse work?**  Yes  No

**Do you have any children?**  Yes  No

If yes, indicate age(s) and whether they live at home: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Yes No**

**Do you have a relative with a physical or mental health problem living at home?**

Explain \_\_\_\_\_  
If yes, do you take care of this relative? \_\_\_\_\_

**Do you now use any tobacco products?**

If yes, specify:  Cigarettes  Chew Tobacco  Snuff Tobacco  Cigars  Pipe  
How much/day? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Did you use any tobacco products in the past?**

If yes, specify:  Cigarettes  Chew Tobacco  Snuff Tobacco  Cigars  Pipe  
For how long? \_\_\_\_\_ How much/day? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**Do you now drink alcohol?**

If yes, specify:  Beer  Wine  Liquor  
How many drinks/week? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Did you drink alcohol in the past?**

If yes, specify:  Beer  Wine  Liquor  
For how long? \_\_\_\_\_ How much/day? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**Do you use recreational drugs?**

If yes, specify:  Marijuana  Cocaine  Speed  Hallucinogens  Narcotics  
For how long? \_\_\_\_\_ How often? \_\_\_\_\_

**Have you ever received treatment for drug and/or alcohol problems?**

If yes, specify when and where \_\_\_\_\_

**Have you had a recent exposure to toxins or poisons?**

If yes, list type \_\_\_\_\_

**Have you ever been outside the continental US?**

If yes, specify where and when \_\_\_\_\_

**Work History**

**Highest grade level achieved in school:**

Grade school  High school  College  Post college  Other

**Present occupation** \_\_\_\_\_

Are you currently working with these symptoms?  Yes  No

When did you stop working? \_\_\_\_\_

**Employer** \_\_\_\_\_ **Length of employment** \_\_\_\_\_

**Job Title** \_\_\_\_\_ **How long have you done this job?** \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Mayfield Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_