



Please use black or blue ink - Please print

Today's Date ____/____/____

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Primary Care Physician

Referring Doctor

Patient Information

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Patient Name

Home Phone

Work Phone

Cell Phone

--	--

Address

City

State

Zip

Social Security No.

--	--	--	--

Date of Birth

Age

Male

Female

email address

--	--

Employer

Occupation

Marital Status

Single

Married

Divorced

Widowed

Other

--

If married, name of spouse

--

Daytime phone for spouse

Please provide an alternate telephone number of a friend or family member (not living with you) for use in the case of emergency.

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Name

Relationship

Daytime Phone

Insurance Information

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Name of Insured

Insured's Date of Birth

Policy Number

--	--	--

Insurance Company

Employer

Work Number

Secondary Insurance Information (if applicable)

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Name of Insured

Insured's Date of Birth

Policy Number

--	--	--

Insurance Company

Employer

Work Number

Physician Information

Primary Care Physician

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

What other physicians have treated you for this problem?

Doctor's Name _____ Type of Doctor _____ Month/Year _____

Patient Name _____

History of Present Illness

Male
Date of Birth Age Female Height Weight Blood Pressure

Are you Right handed Left handed

What is the main reason for your visit today? _____

Are you experiencing any of the following? Check all that apply

- gait or walking problems
- balance problems
- enlargement of hands, feet or face
- urinary incontinence
- disorientation
- facial droop
- excessive thirst
- nausea/vomiting
- difficulty swallowing
- hearing loss
- weight gain
- memory loss
- loss of coordination
- speech problems
- dizziness
- weakness
- lethargy/sleepiness
- excessive urination

These symptoms have been present for 1-7 days 8-14 days 15-21 days 1 month 2 months
 3 months 6 months 9 months 12 months greater than 12 months

These symptoms started on (give specific date, if known) _____

How would you describe your symptoms since they began? better worse no change

How did this problem begin? Please explain: _____

If you answered "yes" to speech problems, please describe the problem you are having: _____

Describe your daily level of function independent/fully active independent/limited to light duty work or light activity
 independent/unable to do any work dependent on others for some of my activities completely dependent on others

Are you having seizures? yes no **If yes, please complete the Seizure Questionnaire below:**

Seizure Questionnaire - complete only if you are having seizures

When was your first seizure? _____ When was your last seizure? _____

How frequent are your seizures? _____

Who has treated you for your seizures? _____

Describe your seizures _____

Have you been given a seizure diagnosis? no grand mal petit mal simple partial complex partial

Seizure Questionnaire, continued

What medications are you currently using for seizures?

Drug Name

Strength

Directions

What medications have you used for seizures in the past?

Drug Name

Strength

Directions

Are you having headaches or facial pain? yes no

If yes, please complete the Headache or Facial Pain Questionnaire below:

Headache or Facial Pain Questionnaire - complete only if you are having headaches or facial pain

Severity of pain (circle one): 1 2 3 4 5 6 7 8 9 10 (1 = least pain 10 = worst pain)

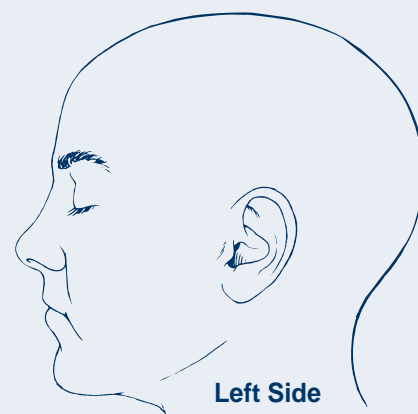
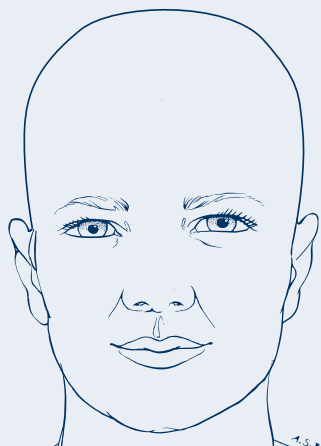
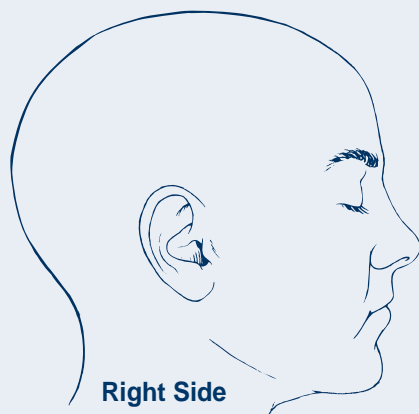
Frequency constant intermittent - how often _____

Timing - pain occurs in the morning in the evening after work wake you from sleep other _____

Location of pain (mark all that apply) forehead behind the right eye behind the left eye

behind both eyes top of the head back of the head left side of face right side of face neck

Please mark (X) where your pain is located:



Headache or Facial Pain Questionnaire, continued

How long have you had this pain?

1-7 days 8-14 days 15-21 days _____month(s) _____year(s)

Associated symptoms (check all that apply) nausea auras weakness numbness visual symptoms

other _____

Quality of the pain? sharp dull throbbing electrical other _____

Do you have a family history of headaches or facial pain? yes no

What treatments have you had for your pain? _____

Do you have a pain diagnosis? no cluster tension migraine trigeminal neuralgia/tic douloureux

other _____

What makes your pain worse? Do certain positions? _____

What makes your pain better? Do certain positions? _____

Does Valsalva (straining or bearing down) make your pain worse? yes no

Are you having visual symptoms? yes no **If yes, please complete the Visual Symptoms Questionnaire below:**

Visual Symptoms Questionnaire - complete only if you are having visual symptoms

Is this problem decreased vision difficulty reading loss of peripheral vision double vision

other _____

Does it affect the right eye left eye both eyes

Are the symptoms constant intermittent

How long have you had these visual symptoms? _____

Have you seen an ophthalmologist? yes no

If yes, who? _____ **When?** _____

Previous Diagnostic Tests

Provide as much information as possible regarding any of the following tests you have had for this illness or injury.

MRA/MRV	Mo./Yr. Where	_____	Vision test	Mo./Yr. Where	_____
MRI scan	___/___	_____	Hearing test	___/___	_____
CT scan	___/___	_____	Angiogram	___/___	_____
PET scan	___/___	_____	Doppler	___/___	_____
Labs	___/___	_____	Other	___/___	_____

Previous Treatment

Previous treatment: please check any of the following treatments you have had and provide the information requested.

	Date(s) performed	Where performed	Who performed
<input type="checkbox"/> surgery	_____	_____	_____
<input type="checkbox"/> biopsy	_____	_____	_____
<input type="checkbox"/> shunt	_____	_____	_____

Radiation therapy

<input type="checkbox"/> external/focused beam	_____
<input type="checkbox"/> whole brain	_____
<input type="checkbox"/> radiosurgery	_____

	Therapy/drug name(s)	Date(s)
<input type="checkbox"/> chemotherapy	<input type="checkbox"/> Temodar <input type="checkbox"/> Avastin <input type="checkbox"/> BCNU <input type="checkbox"/> thalidomide	_____
	<input type="checkbox"/> others _____	_____
<input type="checkbox"/> clinical trials	_____	_____
<input type="checkbox"/> alternative therapies	_____	_____

Medication History

List all medications you are taking now, including "over the counter" and prescription pain medications.

Name	Strength	Directions	Name	Strength	Directions
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you taking blood thinners? yes no If yes, which? aspirin Coumadin Plavix other _____

Allergies

Are you allergic to any medications? yes no **If yes, which medicine?** _____

What happens? _____

Are you allergic to iodine contrast dye shellfish latex tape metals/jewelry

What happens? _____

Do you have any other allergies? yes no **If yes, what are you allergic to?** _____

What happens? _____

Have you ever had an allergic reaction to a blood transfusion? yes no

What happens? _____

Past Surgical/Medical History

Have you ever had any other operations/surgery? yes no

If yes, when? _____ Describe the surgery _____

Have you been diagnosed with any of the following? (check all that apply)

- anemia
- diabetes
- lung disease/COPD/emphysema
- sleep apnea
- angina/chest pain
- elevated cholesterol
- malignancy/cancer
- stroke
- arrhythmia/irregular heartbeat
- heart attack
- mental health disorder/depression/anxiety
- thyroid disease
- asthma
- heart disease
- osteoporosis
- congestive heart failure
- high blood pressure
- peripheral vascular disease
- coronary artery disease
- kidney disease
- phlebitis/bleeding disorder

Do you have any other medical conditions? yes no

If yes, explain _____

Have you ever had angioplasty? yes no

Do you have any stents placed? yes no **If yes, when?** _____

Do you have any other implant devices (i.e., pacemaker, morphine pump, spinal cord stimulator) yes no

Explain _____

Have you ever been treated for blood clots or excessive bleeding? yes no

Is there any reason you cannot receive blood or blood products? yes no

If yes, explain _____

Social History

Do you live alone? yes no
Indicate your marital status single married widowed divorced other
If married, does your spouse work? yes no
Are you pregnant? yes no If yes, when is your due date? _____
Do you have any children? yes no
If yes, indicate sex, age(s) and whether they live at home _____

Are you a veteran? yes no

Do you now use or have you ever used any tobacco products? in the past, but quit yes no
If yes, specify cigarettes chewing tobacco snuff tobacco cigars pipe
How much/day _____ For how many years _____ When did you quit _____

Do you now drink alcohol? yes no recovering alcoholic
If yes, specify beer wine liquor
How many drinks/week _____ For how many years _____

Have you ever used any recreational drugs? in the past, but quit yes no
If yes, specify marijuana cocaine speed hallucinogens narcotics other
How much/day _____ When did you quit _____

Have you ever received treatment for drug and/or alcohol problems? yes no
If yes, specify when and where _____

Have you ever been exposed to radiation? yes no Chemicals? yes no

If yes, describe _____

Work History

Highest level achieved in school grade school high school college post college

Do you work outside the home? yes no

If yes, are you currently working with these symptoms? yes no

If no, when did you stop working? _____

Does your job require you to:
 lift ___ pounds bend
 sit drive a truck or forklift
 use a computer reach over head
 lift over head stand

Did a physician place you off work? yes no If yes, who? _____

Employer _____ Length of employment _____

Job Title _____ How long have you done this job? _____

Family History

Has anyone in your family had any of the following conditions? Please check all that apply.

- Alzheimer's/memory loss life threatening complications Parkinson's breast cancer
- depression/mental problems to anesthesia stroke lymphoma
- diabetes high blood pressure aneurysm leukemia
- heart problems kidney disease brain tumor cancer-other
- blood clots/clotting disorders lung problems lung cancer other problems _____
- multiple sclerosis colon cancer _____

Do you currently have or have you ever had any of the following problems (please answer “Yes” or “No” to every item; do not skip any):

GENERAL

- fever yes no
- chills yes no
- sweats yes no
- fatigue yes no
- malaise (body weakness) yes no
- weight loss yes no

EYES

- blurring yes no
- diplopia (double vision) yes no
- eye irritation yes no
- eye discharge yes no
- vision loss yes no
- eye pain yes no
- photophobia (sensitivity to light) yes no

EAR/NOSE/THROAT

- earache yes no
- ear discharge yes no
- tinnitus (ringing in ears) yes no
- decreased hearing yes no
- nasal congestion yes no
- nosebleeds yes no
- sore throat yes no
- hoarseness yes no
- dysphagia (difficulty swallowing) yes no

HEART

- chest pains yes no
- palpitations yes no
- difficulty breathing on exertion yes no
- difficulty breathing when sitting/standing yes no
- peripheral edema yes no

RESPIRATORY

- cough yes no
- difficulty breathing yes no
- excessive sputum yes no
- hemoptysis (spitting up blood) yes no
- wheezing yes no

GASTROINTESTINAL

- nausea yes no
- vomiting yes no
- diarrhea yes no
- constipation yes no
- abdominal pain yes no
- bloody stool yes no
- jaundice yes no

PSYCHIATRIC

- depression yes no
- anxiety yes no
- memory loss yes no
- hallucinations yes no

GENITOURINARY

- incontinence yes no
- difficulty urinating yes no
- urinating blood yes no
- urinary frequency yes no
- amenorrhea (no menstrual cycle) yes no
- menorrhagia (excessive menstrual flow) yes no
- pelvic pain yes no

MUSCULOSKELETAL

- back pain yes no
- neck pain yes no
- joint pain yes no
- joint swelling yes no
- muscle cramps yes no
- muscle weakness yes no
- stiffness yes no
- arthritis yes no

NEUROLOGIC

- intermittent paralysis yes no
- weakness yes no
- paresthesia (prickly/tingling sensation) yes no
- seizures yes no
- syncope (passing out) yes no
- tremors yes no
- vertigo (dizziness) yes no
- numbness yes no
- imbalance yes no
- incoordination yes no
- headache yes no
- visual changes yes no
- tinnitus (ringing in ears) yes no

ENDOCRINE

- cold intolerance yes no
- heat intolerance yes no
- polydipsia (excessive thirst) yes no
- polyphagia (excessive eating) yes no
- polyuria (excessive urination) yes no
- weight change yes no

HEMATIC/LYMPHATIC

- abnormal bruising yes no
- abnormal bleeding yes no
- enlarged lymph nodes yes no

Patient signature _____ Date _____

Mayfield physician signature _____ Date _____