MAYFIELD Medical History

Today's Date_____/_____/_____ **Please use black or blue ink - Please print**

Primary Care Physician | Referring Doctor Name | Physician of Record

Patient Information

Patient Name | Home Phone | Work Phone | Cell Phone

Address | City | State | Zip | Social Security No.

Date of Birth | Age | If under age 17, provide parent/guardian name(s)/phone number | ☐ Male ☐ Female | email address

Employer | Occupation

Race ☐ Asian ☐ Black or African American ☐ White ☐ Native American ☐ Multiracial ☐ Other_____

Ethnic Group ☐ Hispanic ☐ Non-Hispanic

Preferred language ☐ English ☐ Spanish ☐ German ☐ French ☐ Other_____

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other_____

Name of spouse/partner/significant other (living with you)* | Daytime phone

*This person will be indicated as your primary contact in case of emergency

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

Name | Relationship | Daytime Phone

Who is your Power of Attorney?

Name | Relationship | Daytime Phone

Do you have a Living Will? ☐ Yes ☐ No

Insurance Information

Name of Insured | Insured's Date of Birth | Policy Number

Insurance Company | Employer | Work Number

Personal Injury

Is the reason for your office visit an illness/injury resulting from an automobile accident? ☐ Yes ☐ No

If Yes, specify the following: Date of accident _____ State where accident occured _____

Name of auto insurance provider _____

Workers' Compensation Information

Diagnoses recognized on claim_____

State_____ Date of Injury_____ Claim #_____

Managed Care (MCO) Provider_____ MCO Phone_____

Employer at time of injury _____ ☐ Claim Allowed ☐ Claim Litigated

Patient Name_____ **Medical Record No.**_____

Vital Signs/History of Present Illness

Date of Birth	Age	☐ Male ☐ Female	☐ Right handed ☐ Left handed	Height	Weight	Blood Pressure	Pulse

Indicate the location(s) and side(s) of your body where the symptoms occur.

☐ neck	☐ left	☐ right	☐ hip	☐ left	☐ right	☐ other_____	
☐ upper back	☐ left	☐ right	☐ buttock	☐ left	☐ right		
☐ middle back	☐ left	☐ right	☐ upper leg	☐ left	☐ right	_____	
☐ lower back	☐ left	☐ right	☐ shin/calf	☐ left	☐ right		
☐ shoulder	☐ left	☐ right	☐ hand	☐ left	☐ right		
☐ upper arm	☐ left	☐ right	☐ foot	☐ left	☐ right		
☐ elbow	☐ left	☐ right	☐ toes	☐ left	☐ right		
☐ forearm	☐ left	☐ right					

Describe the sypmtoms you are experiencing:_____

_____

_____

_____

The symptoms began as a result of ☐ an injury at work ☐ a motor vehicle accident ☐ an injury outside of work
☐ spontaneously with no known cause **What was the date of the accident or injury?** _____

Explain how it happened _____

_____

These symptoms have been present for ☐ 1-7 days ☐ 8-14 days ☐ 14-21 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)_____

Has there been any change in your daily activities due to these symptoms? ☐ no ☐ yes
Since what date have you been unable to perform your daily routine?_____
Are you able to work with your condition? ☐ no ☐ yes

Since the onset of symptoms, have you experienced any <u>new</u> problems urinating or having bowel movements?
☐ no ☐ yes

Previous Diagnostic Tests

Check any of the following diagnostic tests, or treatments you have had for this illness or injury

	Mo./Yr.	Where		Mo./Yr.	Where
Plain x-rays	___/___	_____	Bone scan	___/___	_____
MRI scan	___/___	_____	Myelogram	___/___	_____
CT scan	___/___	_____	Other	___/___	_____
EMG/NCV	___/___	_____			

Previous Treatment

List other physicians who have treated you for this problem?

Physician's Name | Specialty | Month/Year Treated

_____

_____

_____

Have you had physical therapy in the last 12 months? ☐ yes ☐ no If yes, please answer the following:

Who is the physical therapy provider?_____

When was your first visit? _____

How many times have you gone?_____

Did your symptoms improve? ☐ yes ☐ no

Treatment types:

☐ aquatics ☐ ice
☐ electrical stimulation ☐ physical conditioning
☐ ultrasound ☐ hot packs
☐ massage ☐ traction
☐ excercises ☐ other_____
☐ manipulation

Have you had epidural steroid injections (ESI) in the last 12 months? ☐ yes ☐ no If yes, please answer the following:

How many injections have you had?_____ When was your first one? _____

Did your symptoms improve? ☐ yes ☐ no When was your last one?_____

Medication History

List all current medications, including "over the counter" medications, prescription medications, and herbal supplements.

Name	Dose	Directions	Name	Dose	Directions

Are you taking blood thinners? ☐ yes ☐ no **If yes, which?** ☐ aspirin ☐ Coumadin ☐ Plavix ☐ other_____

Do you give Mayfield permission to obtain your medication information electronically through our medical records system? ☐ yes ☐ no

Your Pharmacy Name_____**Phone**_____

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

Past Surgical/Medical History

Have you ever had any neck or back operations/surgery? ☐ yes ☐ no

If yes, when?_____Surgeon's name_____

Describe area of spine operated_____

Have you ever had a surgery on your chest? ☐ yes ☐ no
If yes, describe the surgery_____

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
☐ angina/chest pain
☐ arrhythmia/irregular heartbeat
☐ asthma
☐ congestive heart failure
☐ coronary artery disease
☐ diabetes
☐ elevated cholesterol
☐ elevated triglycerides
☐ heart attack
☐ heart disease
☐ high blood pressure
☐ kidney disease
☐ lung disease/COPD/emphysema
☐ malignancy/cancer
☐ malignant hyperthermia
☐ mental health disorder/ depression/anxiety
☐ osteoporosis
☐ peripheral vascular disease
☐ phlebitis/bleeding disorder
☐ sleep apnea
☐ staph infection (e.g. MRSA)
☐ stroke
☐ thyroid disease

If yes, explain _____

Do you have any other medical conditions? ☐ yes ☐ no
If yes, 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_____

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 had a flu shot? ☐ yes ☐ no If yes, when?_____
Have you had a pneumonia vaccine? ☐ yes ☐ no If yes, when?_____

Social History

Are you a veteran? ☐ yes ☐ no

Do you live alone? ☐ yes ☐ no

Indicate your marital status ☐ single ☐ married ☐ widowed ☐ divorced ☐ partner

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_____

_____

Do you currently use or have you ever used any tobacco products? ☐ yes ☐ no ☐ in the past, but quit

If "yes", specify ☐ cigarettes ☐ chewing tobacco ☐ snuff tobacco ☐ cigars ☐ pipe

How much/day?_____For how many years?_____

If "in the past, but quit", when did you quit? _____

Do you currently drink alcohol? ☐ yes ☐ no ☐ recovering alcoholic, since _____

If yes, specify ☐ beer ☐ wine ☐ liquor

How many drinks/week? _____For how many years? _____

Do you currently use or have you ever used any recreational drugs? ☐ yes ☐ no ☐ in the past, but quit

If "yes", specify ☐ marijuana ☐ cocaine ☐ speed ☐ hallucinogens ☐ narcotics ☐ other

How much/day?_____For how many years?_____

If "in the past, but quit", 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 grade level achieved in school ☐ grade school ☐ high school ☐ college ☐ post college

Are you currently employed? ☐ yes ☐ no ☐ retired

Employer_____ **Length of employment** _____

Job title_____ **How long have you done this job?**_____

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

Does your job require you to:

☐ lift_____pounds ☐ use a computer ☐ bend ☐ reach over head

☐ sit ☐ lift over head ☐ drive a truck or forklift ☐ stand

If not currently working, did a physician place you off work? ☐ yes ☐ no

If yes, please list physician's name _____

If not currently working, when did you stop working? _____

Family History

Has a parent, sibling or offspring had any of the following conditions? Please check all that apply and indicate the relationship of the person who has/had the condition.

Condition	Relationship (mother, father, sister, brother, son, daughter)
☐ Alzheimer's/memory loss	
☐ aneurysm	
☐ blood clots/clotting disorders	
☐ depression/mental problems	
☐ diabetes	
☐ heart problems	
☐ high blood pressure	
☐ kidney disease	
☐ life threatening complications to anesthesia	
☐ lung problems	
☐ malignant hyperthermia	
☐ multiple sclerosis	
☐ Parkinson's disease	
☐ stroke	
☐ brain tumor	
☐ breast tumor	
☐ cervical tumor	
☐ colon cancer	
☐ kidney cancer	
☐ leukemia	
☐ liver cancer	
☐ lung cancer	
☐ lymphoma	
☐ ovarian cancer	
☐ pancreatic cancer	
☐ prostate cancer	
☐ skin cancer	
☐ spine tumor	
☐ thyroid cancer	
☐ cancer-other _____	
☐ other problems _____	

Review of Systems

Do you currently have 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
anorexia	☐ 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
syncope (passing out)	☐ 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
change in bowel habits	☐ yes	☐ no
abdominal pain	☐ yes	☐ no
melena (black or tarry stool)	☐ yes	☐ no
bloody stool	☐ yes	☐ no
jaundice	☐ yes	☐ no

PSYCHIATRIC

depression	☐ yes	☐ no
anxiety	☐ yes	☐ no
memory loss	☐ yes	☐ no
hallucinations	☐ yes	☐ no
other mental health problems	☐ yes	☐ no

GENITOURINARY

vaginal discharge	☐ yes	☐ no
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
abnormal vaginal bleeding	☐ 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

SKIN

rash	☐ yes	☐ no
itching	☐ yes	☐ no
dryness	☐ yes	☐ no
suspicious lesions	☐ 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

ALLERGY

urticaria (itching)	☐ yes	☐ no
hay fever	☐ yes	☐ no

IMMUNOLOGIC

persistent infections	☐ yes	☐ no
HIV exposure	☐ yes	☐ no

Patient signature_____ **Date**_____

Mayfield physician signature _____ **Date**_____