MAYFIELD Medical History

Cranial Patient

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

Primary Care Physician | Referring Doctor Name

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

Secondary Insurance Information (if applicable)

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

Insurance Company | Employer | Work Number

Physician Information

What other physicians have treated you for this problem?

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

Patient Name_____ **Medical Record No.**_____

Vital Signs/History of Present Illness

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

What is the main reason for your visit today?_____

_____

_____

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

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

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

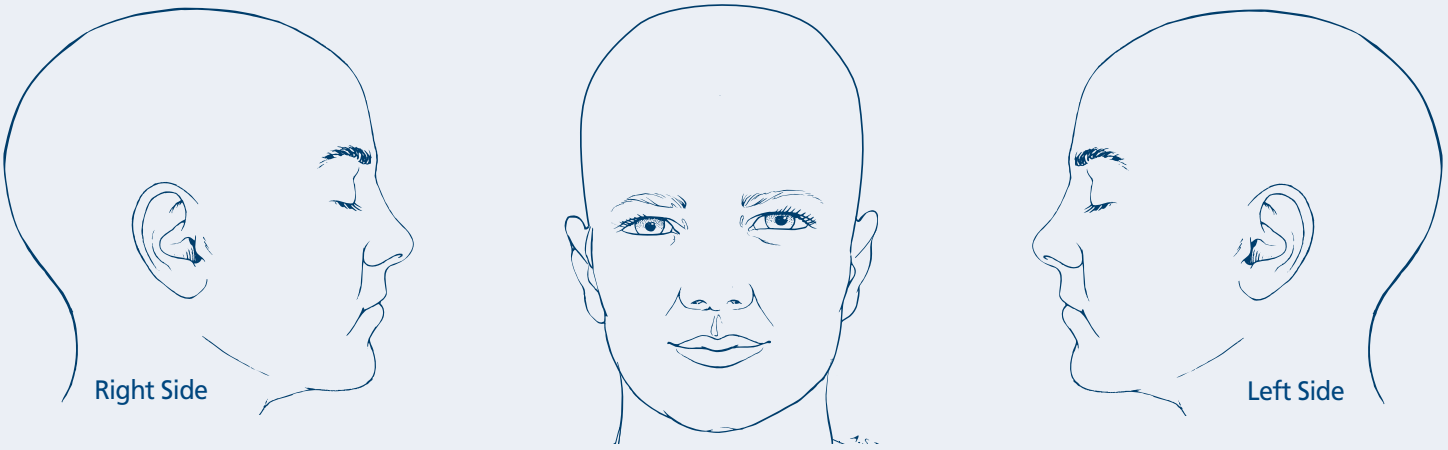
Severity of pain (circle one): 1 2 3 4 5 6 7 8 9 10 (1 = least pain 10 = worst pain)

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.

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

Previous Treatment

Please check the following treatments you have had for your current medical condition and provide the information requested.

	Date(s) performed	Where performed	Who performed
☐ surgery			
☐ biopsy			
☐ shunt			

Radiation therapy

☐ external/focused beam	
☐ whole brain	
☐ radiosurgery	

	Therapy/drug name(s)	Date(s)
☐ chemotherapy	☐ Temodar ☐ Avastin ☐ BCNU ☐ thalidomide ☐ others_____	
☐ clinical trials		
☐ alternative therapies		

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 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? ☐ 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 currently drink alcohol? ☐ yes ☐ no ☐ recovering alcoholic

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? ☐ 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 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 ☐ bend
☐ sit ☐ drive a truck or forklift
☐ use a computer ☐ reach over head
☐ lift over head ☐ 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**_____