Physician services by MAYO CLINIC HEALTH SYSTEM

ABSTRACT

Patient Label

Name: ____ DOB___________Date: ____________

PERSONAL MEDICAL HISTORY (indicate if you have ever been diagnosed with any of the following conditions)

Head/Ears/Eyes/Nose/Throat (HEENT)

Bell's Palsy	___Yes	___No
Cataracts	___Yes	___No
Glaucoma	___Yes	___No
Meniere's syndrome	___Yes	___No
Otosclerosis	___Yes	___No
Recurrent ear infections	___Yes	___No
Recurrent sinusitis	___Yes	___No
Sudden hearing loss	___Yes	___No
Other HEENT history	___Yes	___No

Endocrine

Diabetes mellitus	___Yes	___No
Graves disease	___Yes	___No
Hyperthyroidism (overactive thyroid)	___Yes	___No
Hypothyroidism(underactive thyroid)	___Yes	___No
Prediabetes	___Yes	___No
Other endocrine history	___Yes	___No

Hematology

Anemia	___Yes	___No
Myelodysplasia	___Yes	___No
Other hematology history	___Yes	___No

Respiratory

Allergies/hay fever	___Yes	___No
Asthma	___Yes	___No
COPD	___Yes	___No
Sleep apnea	___Yes	___No
Other respiratory history	___Yes	___No

Cardiovascular

Angina (Chest Pain)	___Yes	___No
Atrial fibrillation (Irregular heart rate)	___Yes	___No
Cardiac arrhythmias (Irregular heart rate)	___Yes	___No
Coronary artery disease	___Yes	___No
Deep vein thrombosis (DVT-Blood Clot)	___Yes	___No
Heart failure	___Yes	___No
Heart valve disease	___Yes	___No
Hyperlipidemia (High cholesterol)	___Yes	___No
Hypertension (High blood pressure)	___Yes	___No
Myocardial infarction (Heart attack)	___Yes	___No
Peripheral vascular disease(poor circulation)	___Yes	___No
Other Cardiovascular history	___Yes	___No

Gastrointestinal

Colitis	___Yes	___No
Diverticulosis	___Yes	___No
GERD (Gastroesophogeal reflux)	___Yes	___No
Irritable Bowel Syndrome	___Yes	___No
Liver disease	___Yes	___No
Pancreatitis	___Yes	___No
Peptic ulcer disease	___Yes	___No
Polyp	___Yes	___No
Other GI history	___Yes	___No

Genitourinary

Chlamydia	___Yes	___No
Gonorrhea	___Yes	___No
Hemodialysis	___Yes	___No
Hernia	___Yes	___No
Herpes genitalis	___Yes	___No
Human papilloma virus (HPV)	___Yes	___No
Kidney disease	___Yes	___No
Kidney failure	___Yes	___No
Kidney stones	___Yes	___No
Past Urinary Tract Infection	___Yes	___No
Peritoneal dialysis	___Yes	___No
Urinary Incontinence	___Yes	___No
Other Genitourinary history	___Yes	___No

Genitourinary - male

Enlarged prostate	___Yes	___No
Erectile dysfunction	___Yes	___No
Testicular problems	___Yes	___No
Undescended testicle	___Yes	___No

Gynecologic

Abnormal pap smear	___Yes	___No
Chronic pelvic pain	___Yes	___No
Endometriosis	___Yes	___No
Pelvic Inflammatory Disease	___Yes	___No
Polycystic ovarian syndrome	___Yes	___No
Recurrent vaginal infect	___Yes	___No
Other gyn history	___Yes	___No

Reproductive history

Age at first period	_________	
Age at menopause	_________	
Pregnancy history		
# of pregnancies	_________	
# of births	_________	
Live births	_________	
Abortions (includes miscarriage/elective termination)		
Total	_________	
Miscarriages	___Yes	___No
Elective terminations	___Yes	___No

Musculoskeletal

Arthritis	___Yes	___No
Fractures	___Yes	___No
Gout	___Yes	___No
Osteopenia	___Yes	___No
Osteoporosis	___Yes	___No
Other musculoskeletal history	___Yes	___No

Name: ____ DOB___________Date: ____________

PERSONAL MEDICAL HISTORY (continued)

Cancer

Condition	Yes	No
Blood cancer	___Yes	___No
Brain cancer	___Yes	___No
Breast cancer	___Yes	___No
Colorectal cancer	___Yes	___No
Endocrine cancer	___Yes	___No
Eye cancer	___Yes	___No
Gastrointestinal cancer	___Yes	___No
Genitourinary cancer	___Yes	___No
Kidney cancer	___Yes	___No
Leukemia	___Yes	___No
Liver cancer	___Yes	___No
Lung cancer	___Yes	___No
Lymphoma	___Yes	___No
Musculoskeletal cancer	___Yes	___No
Neurologic cancer	___Yes	___No
Oral cancer	___Yes	___No
Skin cancer	___Yes	___No
Stomach cancer	___Yes	___No
Thyroid cancer	___Yes	___No
Other cancer history	___Yes	___No

Cancer - female

Condition	Yes	No
Cervical cancer	___Yes	___No
Ovarian cancer	___Yes	___No
Uterine cancer	___Yes	___No

Cancer - male

Condition	Yes	No
Prostate cancer	___Yes	___No
Testicular cancer	___Yes	___No

Infectious disease

Condition	Yes	No
AIDS	___Yes	___No
Chicken pox	___Yes	___No
Hepatitis	___Yes	___No
HIV	___Yes	___No
Measles	___Yes	___No
MRSA	___Yes	___No
Mumps	___Yes	___No
Polio	___Yes	___No
Positive TB	___Yes	___No
Rheumatic fever	___Yes	___No
Rubella	___Yes	___No
Syphilis	___Yes	___No
Tuberculosis	___Yes	___No
Vanc-resistant enterococcal	___Yes	___No
Other infectious disease history	___Yes	___No

Skin

Condition	Yes	No
Acne	___Yes	___No
Eczema	___Yes	___No
Psoriasis	___Yes	___No
Other skin history	___Yes	___No

Neurologic

Condition	Yes	No
ADHD	___Yes	___No
Autism	___Yes	___No
Dementia	___Yes	___No
Developmental delay	___Yes	___No
Headaches	___Yes	___No
Multiple sclerosis	___Yes	___No
Peripheral neuropathy	___Yes	___No
Restless leg syndrome	___Yes	___No
Seizures	___Yes	___No
Stroke	___Yes	___No
Transient ischemic attack (TIA)	___Yes	___No
Other neurological history	___Yes	___No

Psychiatric

Condition	Yes	No
Anorexia Nervosa	___Yes	___No
Anxiety	___Yes	___No
Bipolar disorder	___Yes	___No
Bulemia	___Yes	___No
Depression	___Yes	___No
Schizophrenia	___Yes	___No
Other psychiatric history	___Yes	___No

Genetic/metabolic

Condition	Yes	No
Cystic fibrosis	___Yes	___No
Down syndrome	___Yes	___No
Other genetic history	___Yes	___No
Other metabolic history	___Yes	___No

Events

Condition	Yes	No
Anaphylaxis	___Yes	___No
Gunshot wound	___Yes	___No
Motor Vehicle Accident	___Yes	___No
Other events	___Yes	___No

Disabilities

Condition	Yes	No
Hearing deficit	___Yes	___No
Vision deficit	___Yes	___No
Hemiparesis (One side weakness)	___Yes	___No
Paraplegia	___Yes	___No
Quadriplegia	___Yes	___No
Other disabilities	___Yes	___No

Name: ____ DOB____________Date: ____________

SURGICAL HISTORY (indicate if you have had any of the following surgical procedures)

Head/Ears/Eyes/Nose/Throat

Adenoidectomy ___Yes ___No
Adenotonsillectomy ___Yes ___No
Cataract extraction ___Yes ___No
Ear tubes ___Yes ___No
Endoscopic sinus surgery ___Yes ___No
Laryngectomy ___Yes ___No
Mastoidectomy ___Yes ___No
Septoplasty ___Yes ___No
Stapedectomy ___Yes ___No
Tonsillectomy ___Yes ___No
Tympanoplasty ___Yes ___No
UPPL ___Yes ___No
Other head surgery ___Yes ___No
Other eye surgery ___Yes ___No
Other ear surgery ___Yes ___No
Other nasal surgery ___Yes ___No
Other throat surgery ___Yes ___No

Endocrine

Parathyroidectomy ___Yes ___No
Thyroid surgery ___Yes ___No
Other endocrine surgery ___Yes ___No

Respiratory

Bronchoscopy ___Yes ___No
Lobectomy ___Yes ___No
Other chest surgery ___Yes ___No

Cardiovascular

Angiogram ___Yes ___No
Angioplasty ___Yes ___No
Coronary artery bypass ___Yes ___No
Carotid endarterectomy ___Yes ___No
Coronary stent ___Yes ___No
Heart transplant ___Yes ___No
Pacemaker ___Yes ___No
Valve replacement ___Yes ___No
Other cardiac surgery ___Yes ___No

Gastrointestinal

Appendectomy ___Yes ___No
Cholecystectomy (Gallbladder surgery) ___Yes ___No
Colectomy (Colon removal) ___Yes ___No
Colon polypectomy ___Yes ___No
Gastric bypass ___Yes ___No
Splenectomy ___Yes ___No
Other Gastrointestinal surgery ___Yes ___No

Genitourinary

Bladder surgery ___Yes ___No
Hernia Repair ___Yes ___No
Kidney stone extraction ___Yes ___No
Nephrectomy (Kidney removed) ___Yes ___No
Other Genitourinary surgery ___Yes ___No

Genitourinary - male

Prostatectomy (Prostate removed) ___Yes ___No
TURP (Prostate repair) ___Yes ___No
Vasectomy ___Yes ___No

Gynecologic

Ablation ___Yes ___No
Cervical conization/LEEP ___Yes ___No
C-Section ___Yes ___No
D&C ___Yes ___No
Hysterectomy ___Yes ___No
Oophorectomy(Ovary removal) ___Yes ___No
Tubal ligation ___Yes ___No
Other gyn surgery ___Yes ___No

Musculoskeletal

Arthroscopic surgery ___Yes ___No
Back surgery ___Yes ___No
Carpal tunnel release ___Yes ___No
Fracture surgery ___Yes ___No
Joint replacement ___Yes ___No
Other musculoskeletal srg ___Yes ___No

Skin

Skin cancer removal ___Yes ___No
Other skin surgery ___Yes ___No

Neurologic

Craniotomy ___Yes ___No
Spinal surgery ___Yes ___No
Other neurologic surgery ___Yes ___No

Neurologic

Craniotomy ___Yes ___No
Spinal surgery ___Yes ___No
Other neurologic surgery ___Yes ___No
Other neurologic surgery ___Yes ___No

Breast

Breast biopsy ___Yes ___No
Lumpectomy ___Yes ___No
Mastectomy ___Yes ___No
Other breast surgery ___Yes ___No

FAMILY MEDICAL HISTORY (indicate if any of your blood relatives have had the following conditions)

Condition					Condition				
Alcoholism	❑Self	❑Parent	❑Sibling	❑Other	Hyperlipidemia (High Cholesterol)	❑Self	❑Parent	❑Sibling	❑Other
Asthma	❑Self	❑Parent	❑Sibling	❑Other	Hypertension (High Blood Pressure)	❑Self	❑Parent	❑Sibling	❑Other
Atherosclerosis(hardening of the arteries)	❑Self	❑Parent	❑Sibling	❑Other	Kidney disease	❑Self	❑Parent	❑Sibling	❑Other
Autoimmune disease	❑Self	❑Parent	❑Sibling	❑Other	Mental illness	❑Self	❑Parent	❑Sibling	❑Other
Blood disorders	❑Self	❑Parent	❑Sibling	❑Other	Osteoporosis	❑Self	❑Parent	❑Sibling	❑Other
Breast cancer	❑Self	❑Parent	❑Sibling	❑Other	Other cancer	❑Self	❑Parent	❑Sibling	❑Other
Colorectal cancer	❑Self	❑Parent	❑Sibling	❑Other	Other cardiac disorders	❑Self	❑Parent	❑Sibling	❑Other
Coronary artery disease	❑Self	❑Parent	❑Sibling	❑Other	Ovarian cancer	❑Self	❑Parent	❑Sibling	❑Other
Dementia	❑Self	❑Parent	❑Sibling	❑Other	Parent with hip fracture	❑Self	❑Parent	❑Sibling	❑Other
Depression	❑Self	❑Parent	❑Sibling	❑Other	Prostate cancer	❑Self	❑Parent	❑Sibling	❑Other
Diabetes mellitus	❑Self	❑Parent	❑Sibling	❑Other	Rheumatoid disease	❑Self	❑Parent	❑Sibling	❑Other
Drug abuse	❑Self	❑Parent	❑Sibling	❑Other	Stroke	❑Self	❑Parent	❑Sibling	❑Other
Hearing problems	❑Self	❑Parent	❑Sibling	❑Other	Thyroid disease	❑Self	❑Parent	❑Sibling	❑Other
Hepatitis B	❑Self	❑Parent	❑Sibling	❑Other	Tuberculosis	❑Self	❑Parent	❑Sibling	❑Other
					Vision problems	❑Self	❑Parent	❑Sibling	❑Other

Family History Comments: ______________________ Other: ______________________

SOCIAL HISTORY (please answer the following questions regarding your health and habits)

Educational Level Completed ❑ <8th Grade ❑ High School ❑ 2 years College ❑ >4 years

Household members ______________________

Leisure activities ______________________

Marital status ❑ Married ❑ Divorced ❑ Seperated ❑ Single

Military service ___Yes ___No Comments: ______________________

Occupation ______________________

Occupational exposures ___Yes ___No Comments: ______________________

Pets ___Yes ___No Comments: ______________________

Sexual history # of sexual contacts in the past 10 years ______________________

Travel history (Outside the Unites States) ______________________

Dietary habits

Well-balanced diet
- ____ Daily or most days
- ____ About half
- ____ Rarely or never
- ____ Other

High-fat food intake
- ____ 0-1 times daily
- ____ 2 times daily
- ____ 3 or more times/day
- ____ Other

Daily servings fruits/veg
- ____ 0-1
- ____ 2-4
- ____ 5 or more
- ____ Other

Daily servings milk/calcium
- ____ 0-1
- ____ 2-3
- ____ 4 or more
- ____ Other

Eating out
- ____ Rarely or never
- ____ 1-3 times/week
- ____ 4 or more times/wk
- ____ Other

Reads food labels
- ____ Usually or always
- ____ Sometimes
- ____ Seldom or never
- ____ Other

Weight described as
- ____ 0-5 lbs over
- ____ 6-15 lbs over
- ____ > 15 lbs over
- ____ 0-5 lbs under
- ____ 6-15 lbs under
- ____ > 15 lbs under
- ____ Other

During past year weight has
- ____ Remained stable
- ____ Decreased > 10 lbs
- ____ Increased > 10 lbs
- ____ Other

Name: ____ DOB____________Date: ____________

Exercise/physical activity

Physical activity

____ None
____ Walking
____ Running
____ Bicycling
____ Swimming
____ Yoga
____ Aerobics
____ Weight training
____ Other

Frequency

____ 1-2 times per week
____ 3-4 times per week
____ 5-6 times per week
____ Daily
____ Other

Duration

____ < 15 minutes/day
____ 15-30 minutes/day
____ 30-45 minutes/day
____ 45-60 minutes/day
____ 60-90 minutes/day
____ > 90 minutes/day
____ Other

Substance Abuse

Tobacco status

____ Has never used tobacco
____Current every day smoker
____Current some day smoker
____Former tobacco use
____Smoker, current status unknown
____Unknown if ever smoked
____Smokeeless tobacco user

Smoking history

(pack years=# of packs/day multiplied by years smoked)

____ < 10 pack years
____ 10-25 pack years
____ 25-50 pack years
____ > 50 pack years

Quit status

____ Considering quitting
____ Not considering quitting
____ Quit date established
____ Secondhand exposure
____ Other

Counseling given

____Patient declined
____Provider counseling
____Support medications
____Support program
Other __________________

Packs/day ______________________________

Alcohol intake

____ None
____ 0-2 drinks per day
____ 2+ drinks per day
____On social occasions
____ Other

Counseling given

____None
____Provider counseling
____Reduced to 2 or less per day
____Support program
Other ______________________

Substance use

____ Denies use
____ Marijuana
____ Cocaine/crack
____ Amphetamines
____ Hallucinogens
____ Tranquiliz./sedatives
____ Opiates
____ Painkillers
____ Club/designer drugs
____ Inhalants
____ Injection drugs
____ Other

Counseling given:

____Patient declined
____Provider counseling
____Support medications
____Support program
____Treatment program
____None
Other: _______________

Caffeine use

Never
____1-2 a day
____3-4 a day
____Over 5

Faith/religion

Faith tradition/religion

____ Christianity
____ Judaism
____ Islam
____ Buddhism
____ Hinduism
____ Alternative faith

Special faith needs ___Yes ___No Comments: ______________________________

Vehicle safety

Seatbelt use

____ Always
____ Sometimes
____ Never
____ Other

Helmet use

____ Always
____ Sometimes
____ Never
____Doesn't ride bike
____ Other

Drive intoxicated or ride w/intoxicated driver

____ Never
____ Rarely
____ Weekly
____ Daily
____ Other

Home safety

Water heater temp set	___Yes	___No
<120 degrees	___Yes	___No
Working smoke detector in home	___Yes	___No
Fire extinguisher in home	___Yes	___No
Carbon monoxide detector in home	___Yes	___No
Firearms in home	___Yes	___No
Firearms unloaded and locked	___Yes	___No

Personal safety

Victim of physical abuse	___Yes	___No
Victim of emotional abuse	___Yes	___No

Any additional information ____

Patient Signature____ Date_____________________

Physician Signature____ Date_____________________