Physician services by MAYO CLINIC HEALTH SYSTEM

Patient Sticker

Personal, Family and Social Medical History

Please mark **YES** for any personal history of each diagnosis and **enter age of onset.**
If you have NO PERSONAL HISTORY, please check **NONE** at the beginning of each category and skip to the next section.

ANESTHESIA HISTORY			
If no history of problems with Anesthesia, check NONE and skip section.	NONE ☐		
	AGE	YES	NO
Difficult Airway/Intubation		☐	☐
Family History of Malignant Hyperthermia		☐	☐
Personal History of Malignant Hyperthermia		☐	☐
Post-op nausea & vomiting		☐	☐
Post-Dural puncture headache		☐	☐
Postoperatvie Delirium/Confusion		☐	☐
Pseudocholinesterase Deficiency		☐	☐

MEDICAL HISTORY			
If no history, check NONE and skip section.	NONE ☐		
	AGE	YES	NO
Arthritis		☐	☐
Asthma		☐	☐
Bleeding/Coagulation		☐	☐
Cancer Type:		☐	☐
Chronic Lung Disease		☐	☐
Diabetes Mellitus		☐	☐
GI Problems (Stomach, intestine, etc)		☐	☐
Hearing Impairment		☐	☐
Heart Disease		☐	☐
Hypertension (High Blood Pressure)		☐	☐
Liver Disease		☐	☐
Mental Health		☐	☐
Musculo-Skeletal Disease		☐	☐
Neurological Disease		☐	☐
Peripheral Vascular Disease		☐	☐
Renal Disease (Kidney)		☐	☐
Seizures		☐	☐
Skin Problems		☐	☐
Stroke/TIA		☐	☐
Vision Impairment		☐	☐

SURGICAL HISTORY			
If no history, check NONE and skip section.	NONE ☐		
	AGE	YES	NO
Abdominal Aortic Aneurysm Repair		☐	☐
Appendectomy		☐	☐
Cardiac Bypass		☐	☐
Cataract Removal		☐	☐
Cholecystectomy (Gall Bladder)		☐	☐
Colon Resection		☐	☐
Hip Replacement (Left, Right, Both?)		☐	☐
Hysterectomy		☐	☐
Knee Replacement (Left, Right, Both?)		☐	☐
Mastectomy		☐	☐
Prostatectomy		☐	☐
Sinus Surgery		☐	☐
Splenectomy		☐	☐
Tonsillectomy		☐	☐
Transurethral Resection of Prostate		☐	☐
Other (Specify)		☐	☐

GYNECOLOGY HISTORY	
If no history, check NONE and skip section.	NONE ☐
Age at menarche (Your first period)	________years of age
Age at menopause	________years of age
Months Breastfeeding	________# of Months

Additional information about your personal health history.

____
____
____
____
____
____
____

Patient Sticker

PAGE 2

Personal, Family and Social Medical History

ACTIVITIES OF DAILY LIVING / OTHER		
If no history, check NONE and skip section.	NONE ☐	
	YES	NO
Military Service	☐	☐
Caffeine Concern	☐	☐
Hobby Hazards	☐	☐
Stress Concerns	☐	☐
Special Diet	☐	☐
Exercise	☐	☐
Seat Belt	☐	☐
Travel History	☐	☐
Carbon Monoxide Detector	☐	☐
Blood Transfusions	☐	☐
Occupational Exposure	☐	☐
Sleep Concern	☐	☐
Weight Concern	☐	☐
Back Care	☐	☐
Bike Helmet	☐	☐
Self-Exams	☐	☐
Previous Residences	☐	☐
Radon Testing	☐	☐

SOCIAL HISTORY		
If no history, check NONE and skip section.	NONE ☐	
Sexual Activity Yes ☐ No ☐ Not Currently ☐		
Birth control/Protection		
	Abstinence	☐
	Condom	☐
	Diaphragm	☐
	IUD	☐
	Pill	☐
	Patch	☐
	Vaginal Ring	☐
	Injection	☐
	Spermicide	☐
	Surgical	☐
	Implant	☐
	Natural Family Planning	☐
Partners	Male	☐
	Female	☐

NICOTINE USE	
Never Smoked	NONE ☐
Former Smoker Quit Date:	Yes ☐ No ☐
Passive Smoke Exposure	Yes ☐ No ☐
Current Smoker	Yes ☐ No ☐
Type: ☐Cigarettes ☐Pipe ☐Cigars ☐Hookah ☐E-Cigarettes	
Packs Per Day (circle choice) 1/4 1/2 1 1.5 2 3 +	
Number of Years:	
Smokeless Tobacco	Yes ☐ No ☐
Quit Date:	
Type Snuff	☐
Chew	☐
Number of years?	

ALCOHOL USE	
If no history, check NONE and skip section.	NONE ☐
	Yes ☐ No ☐
	Drinks Per Week
Wine	
Cans of Beer	
Shots of Liquor	
Other	

DRUG USE	
If no history, check NONE and skip section.	NONE ☐
Types: Marijuana	Yes ☐ No ☐
Methamphetamines	Yes ☐ No ☐
Cocaine	Yes ☐ No ☐
IV Drugs	Yes ☐ No ☐
Times per week?	

SOCIOECONOMIC HISTORY
Occupation:
Employer:
Marital Status (circle one): Divorced Life Partner Married Separated Single Widowed
Spouse Name:
Number of Children:
Years of Education:

Patient Sticker

Personal, Family and Social Medical History

Family History
☐Adopted
☐Family History Unknown

Relationship	Status Enter first letter for: Alive Deceased Unknown	No Known Problems	Arthritis	Asthma	Birth Defects	Bleeding Problem	Cancer (include type)	Dementia	Depression	Diabetes	Eczema (skin)	Emphysema (lungs)	Genetic Disease	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Migraines	Obesity	Osteoporosis	Seizures	Stroke	Substance Abuse	Thyroid Disease	Tuberculosis	Other
Enter AGE OF ONSET in the corresponding box (if known). *If not known enter X.* ***Enter TYPE OF CANCER (if known).***																										
Mother Name:																										
Father Name:																										
Sister Name:																										
Brother Name:																										
Maternal Aunt Name:																										
Maternal Uncle Name:																										
Paternal Aunt Name:																										
Paternal Uncle Name:																										
Maternal Grandmother Name:																										
Maternal Grandfather Name:																										
Paternal Grandmother Name:																										
Paternal Grandfather Name:																										
Daughter Name:																										
Son Name:																										
Other Name:																										
Other Name:																										
Other Name:																										
Other Name:																										