IGEN 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	☐ Male ☐ Female	☐ Right handed ☐ Left handed	Height	Weight	Blood Pressure	Pulse

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

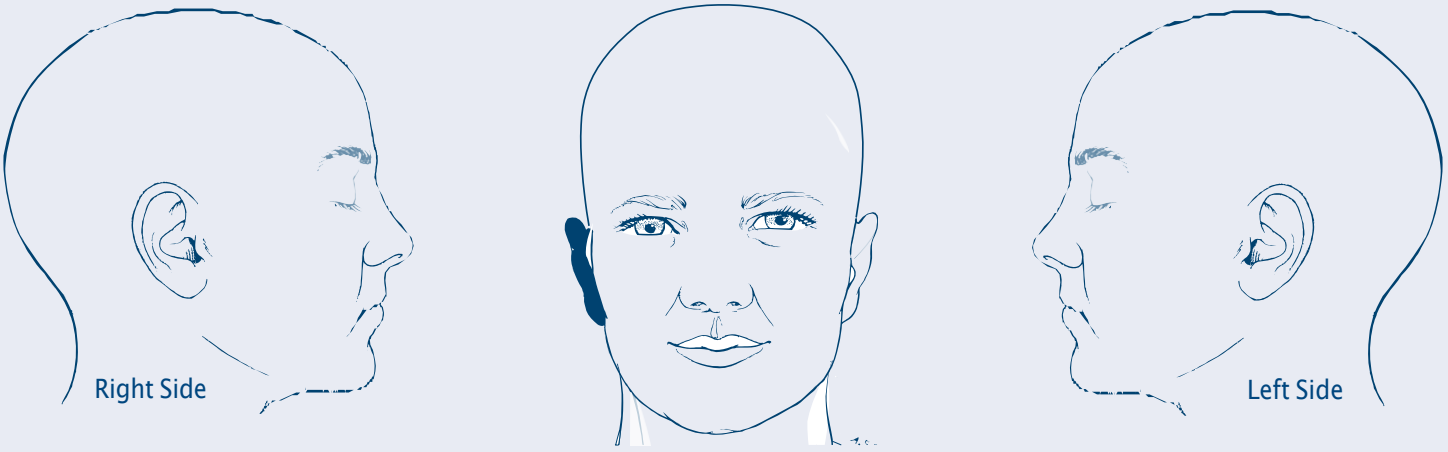
Severity of pain (circle one): 1 2 3 4 5 6 7 8 9 10 (1 = least pain 10 = worst pain)

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** _____

IGEN physician signature _____ **Date** _____