MAYO CLINIC

Information For Your Physician

Complete BOTH SIDES in blue or black ink only

Reset Print

Number (above) and Name

Please answer the following questions and bring this record to your first examination. It will help your physician to know not only about your health but also about your family and relatives.

Patient Name		**Clinic Number**	**Today's Date**
Current Age	**Place of Birth**	**Race or nationality of parents**	

Are you employed? ☐ Yes ☐ No ☐ Retired If yes, what is your occupation? _____

Have you traveled outside the USA and Canada in the past 5 years? ☐ Yes ☐ No If yes, where? _____

	Living	Present age or age at death	Significant health problems or cause of death
Father	☐ Yes ☐ No		
Mother	☐ Yes ☐ No		
Spouse / Domestic Partner	☐ Yes ☐ No		

Present marriage/relationship (years) _____ Previous marriage(s)/relationship(s)(years) _____

	Number living	Number non-living	Significant health problems	Cause(s) of death
Brothers				
Sisters				
Children				

Please check illnesses which have occurred in any of your **blood** relatives:

☐ Bleeding tendencies ☐ Diabetes ☐ High blood pressure ☐ Nervous disease
☐ Cancer ☐ Heart disease ☐ Kidney disease ☐ Stroke

Please check illnesses or conditions which **you** have had:

☐ Asthma ☐ Bleeding tendencies ☐ Cancer ☐ Diabetes
☐ Glaucoma ☐ HIV ☐ Heart trouble ☐ Hepatitis
☐ High blood pressure ☐ Jaundice ☐ Kidney disease ☐ Nervous disorder
☐ Pneumonia ☐ Rheumatic fever ☐ Stroke/TIA ☐ Tuberculosis
☐ Hypothyroidism ☐ Sleep apnea ☐ Reflux/peptic ☐ Blood clots
☐ Obesity ☐ Elevated cholesterol ☐ Other _____

What type of physical activities do you perform (including Yoga, Tai Chi, etc.)? _____

Do you engage in any other healing or alternative therapies (e.g. acupuncture, massage, hypnosis, etc.)?

_____

Previous operations (please list procedure and year)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you had any serious injuries, broken bones, etc.? ☐ Yes ☐ No
If yes, please list: _____

Have you ever had an allergic reaction to any medications? ☐ Yes ☐ No
If yes, which medications and what type of reaction? _____

Have you ever had an allergic reaction to X-ray contrast dye? ☐ Yes ☐ No
If yes, please describe: _____

Have you ever had a latex allergy? ☐ Yes ☐ No

Have you ever had a tape allergy? ☐ Yes ☐ No

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	Never	Now	In the past	How much each day?	For how many years?	When did you quit?
Tobacco use	☐	☐	☐			
Alcohol use	☐	☐	☐			
Recreational drug use	☐	☐	☐			

Please check the diseases against which you have been immunized:

☐ Pneumoccal Pneumonia ☐ Hepatitis A ☐ Measles ☐ German measles (Rubella)
☐ Polio ☐ Hepatitis B ☐ Tetanus ☐ Influenza

Prescription Medications	Dosage (mg)	Frequency (once, twice, etc., per day)

Non Prescription Medications (including over-the-counter drugs, supplements, herbs, vitamins, etc.)		

Have you taken cortisone-type drugs? ☐ Yes ☐ No

Have you ever had blood products transfused? ☐ Yes ☐ No
If yes, when? _____ where? _____

When was your most recent proctoscopic/sigmoidoscopic/barium enema/colonoscopic exam? _____

What is your usual weight? _____ How long have you been at this weight? _____

Women Only

History of abnormal Pap smear? ☐ Yes ☐ No
Last menstrual period _____
Last Pap smear? _____
Most recent mammogram? _____
Periods are ☐ regular ☐ irregular
Number of pregnancies _____
Number of miscarriages _____

What is your main medical problem now, and how long have you had it?

What other medical problem(s) do you want us to know about?

Non-Mayo physician involved in your care:

Name			
Address	**City**	**State**	**Postal Code**
In order to support your continuing care, Mayo Clinic may share a summary of your findings with the above listed physician.			