Patient Medical History

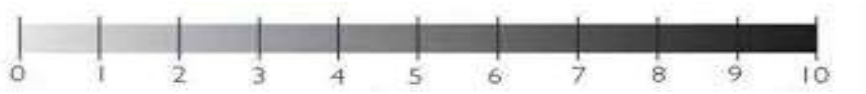
Mayo Family Healthcare
BillieSue Mayo, Nurse Practitioner
Primary and Urgent Care

Name:_____ **Sex:** F / M **DOB:**_____ **Date:**_____

What brings you in today:_____

Are you in pain? □Yes □No

**If 'Yes' please circle your pain level on the scale.



ALLERGIES TO MEDICATION: Please list medication and the reaction that occurs

CURRENT MEDICATIONS: List ALL MEDICATIONS you take, including over the counter (OTC) medications and vitamins. Include specific doses and when taken. If you do not know, please call your pharmacist to confirm.

CURRENT MEDICAL HISTORY: Please check applicable history

□ Diabetes □ Hypertension □ Cardiovascular disease □ Heart Attack □ Seizure Disorder □ Stroke □ Depression □ Anxiety □ Obesity □ Arthritis □ Fibromyalgia/Myositis □ Asthma □ Hypothyroidism □ Miscarriages_____ □ Pregnancies_____
□ Seasonal Allergies

Other: _____

Last Menstrual Period: _____ □Regular □ Abnormal

Date of last Colonoscopy: _____ Date of last Mammogram: _____

Have you had the following vaccinations? Where was the vaccine done (doctor, pharmacy, etc.) ?

□ **Influenza**, Year:_____ □ **Pneumococcal**, Year:_____ □**Tetanus**, Year:_____

Covid-19 □ Pfizer: Month/Year_____ □ Moderna: Month/Year_____ □ Johnson & Johnson: Month/Year_____

SOCIAL/CULTRUAL HISTORY:

Are there any limitations to understanding or following instructions (either written or verbal)? □Yes □No

Current living situation (Check all that apply): ☐ Single Family Household □ Multi-generational □ Homeless ☐ Shelter □ Skilled Nursing Facility □ Other:_____

DO YOU FEEL SAFE: □Yes □No

Do you use recreation drugs? □Yes □No If yes, what type and frequency? _____

Do you consume caffeine? □Yes □No If yes, how many cups a day? _____

Exposed to secondhand smoke? □Yes □No

Are you on a special diet? □Yes □No If yes, please describe? _____

Are you a: □Current smoker □Former smoker □Never smoker □ Vape with nicotine

If 'current' smoker': When did you start smoking? _____

If 'current smoker': How often do you smoke cigarettes? □Every day □Some days, but not everyday

If 'current smoker': How many cigarettes a day do you smoke? _____

If current smoker': How soon after you wake up do you smoke your first cigarette? (As soon as you wake up, 15 min after, 30 min after, an hour after?) _____

If 'current smoker': Are you interested in quitting? □Ready to quit □Thinking about quitting □Not ready to quit

Do you drink alcohol? □Yes □No

If 'Yes': How often did you have a drink containing alcohol in the past year?
□ Never (0 point)
□ Monthly or less (1 point)
□ 2 to 4 times a month (2 points)
□ 2 to 3 times a week (3 points)
□ 4 or more times a week (4 points)
If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?
□ 1 or 2 drinks (0 point)
□ 3 or 4 drinks (1 point)
□ 5 or 6 drinks (2 points)
□ 7 to 9 drinks (3 points)
□ 10 or more drinks (4 points)
If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?
□ Never (0 point)
□ Less than monthly (1 point)
□ Monthly (2 points)
□ Weekly (3 points)
□ Daily or almost daily (4 points)

Do you have any limitations understanding or following instructions (either written or verbal)? □ Yes □ No

FAMILY HISTORY (Circle all that apply):

FATHER: Living Age: _____ Deceased Age: _____

Alcoholism	Bipolar Disorder	Depression	Heart Attack	Migraines
Anemia	Cancer Type:	Diabetes 1 or 2	High Cholesterol	Osteoporosis
Asthma	COPD/Emphysema	DVT (Blood Clot)	High Blood Pressure	Stroke
Arthritis	Dementia	Heart Disease	Kidney Disease	Thyroid Disorder

MOTHER: Living Age: _____ Deceased Age: _____

Alcoholism	Bipolar Disorder	Depression	Heart Attack	Migraines
Anemia	Cancer Type:	Diabetes 1 or 2	High Cholesterol	Osteoporosis
Asthma	COPD/Emphysema	DVT (Blood Clot)	High Blood Pressure	Stroke
Arthritis	Dementia	Heart Disease	Kidney Disease	Thyroid Disorder

SURGICAL HISTORY: Please list all prior surgeries and approximate dates they were performed.

PATIENT CARE TEAM: Please list all other medical providers you see on a regular basis (i.e., Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

CURRENT SYMPTOMS THAT YOU ARE HAVING TODAY (Circle all that apply):

GENERAL HEALTH	GENITOURINARY	RESPIRATORY	ALLERGY
Good general health	Blood in Urine	Shortness of Breath	Itching
Weight Gain	Pain in lower back	Shortness of Breath at rest	Seasonal Allergies
Weight Loss	Frequent urination	Wheezing	Sneezing
Fever	Painful or burning urination	Shortness of breath with exertion	Watery eyes
Fatigue	Urine retention	Chest Pain	Rash
Difficulty sleeping	Urine incontinence	Pain with inspiration	Hives
Chills			Congestion/Cough
Other:	Other:	Other:	Other:

EAR, NOSE, THROAT, MOUTH	PSYCHIATRIC	NEUROLOGICAL	OPHTHALMOLOGIC
Difficulty swallowing	Depressed Mood	Balance Issues	Blurred vision
Earache	Anxiety	Headache	Loss of vision
Loss of hearing/deafness	Eating disorder	Memory loss	Eye pain
Painful chewing	Nervous breakdown	numbness	Dry eyes
Ringing in ears	Suicidal thoughts	tingling	Watery eyes
Other:	Other:	Other:	Other:

SKIN	CARDIOVASCULAR	MUSCLES/JOINTS/BONES	ENDOCRINE
Rash or itching	Chest pain	Back pain	Cold intolerance
Sun sensitivity	Irregular heartbeat	Limping Gait	Heat intolerance
Hair loss	Shortness of breath	Joint pain	Unexplained weight loss
Changing Moles	Dizziness	Joint stiffness/swelling	Hot flashes
Discoloration	Weakness	Muscle pain/tenderness	
Eczema	Palpitations	Arthritis	
Other:	Other:	Other:	

Patient or Guardian Signature: _____ Date:_____/_____/_____

Relationship to Patient: _____

Printed name: _____