MAYFIELD History of Present Illness

Cranial Patient

Today's Date_____/_____/_____ **Please use black or blue ink - Please print**

Patient Name | Date of Birth

History of Present Illness

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:_____

_____

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

Patient Name_____ Medical Record No._____

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

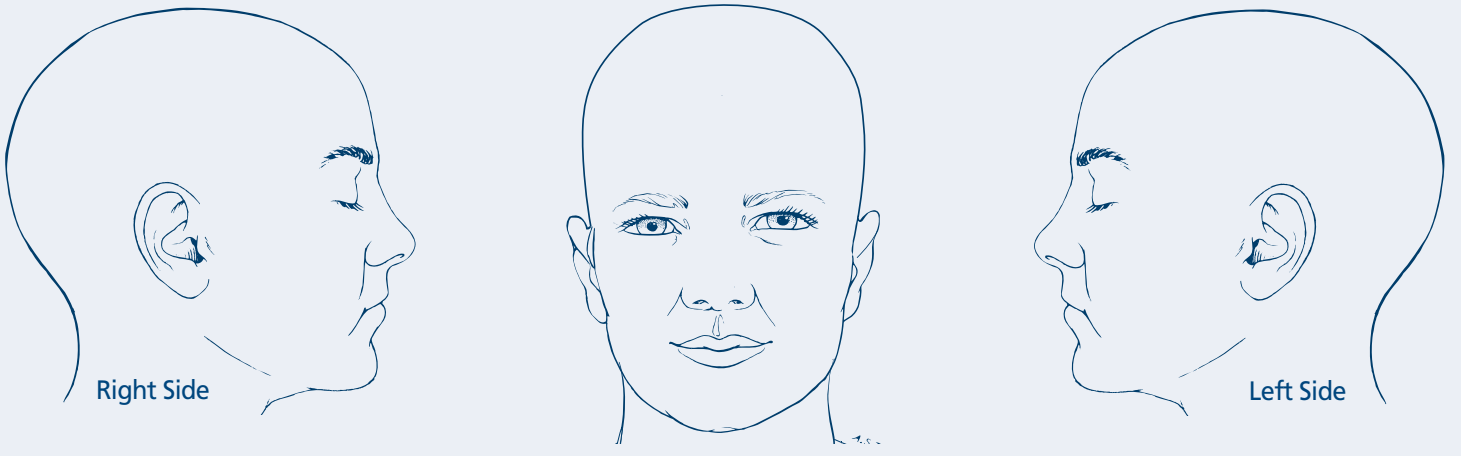
Severity of pain (circle one): 1 2 3 4 5 6 7 8 9 10 (1 = least pain 10 = worst pain)

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		

Mayfield provider signature _____ **Date**_____