MAINLAND MULTI-SPECIALTY GROUP, PLLC
MARILYN MARX, MD, MBA, FACS

NAME________________________________ TODAY'S DATE __________

STREET____________________ CITY______________ STATE______ZIP__________

HOME # ______________ CELL # __________________ WORK # ______________

OCCUPATION______________________ AGE:______ DATE OF BIRTH ____________

REFERRED BY ______________________________ SS#____________________

MARITAL STATUS______________________ ☐Single ☐Married ☐Widowed ☐Divorced

☐Caucasian ☐Black ☐Hispanic ☐Other

EMAIL ADDRESS____

BRIEFLY, WHAT IS THE PURPOSE OF THIS VISIT?

HISTORY OF PRESENT ILLNESS: (Leave this blank, the Dr. will discuss with you.)

Location
Quality
Severity
Duration
Timing
Context
Modifying Factors
Assoc. S/Sxs

Family History:
Have you or any member of your family had any of the following:

			What Relative / Yourself
Cancer/Leukemia	N	Y	______/______
Tuberculosis	N	Y	______/______
Diabetes	N	Y	______/______
Heart Trouble	N	Y	______/______
Heart Attack	N	Y	______/______
High Blood Pressure	N	Y	______/______
Stroke	N	Y	______/______
Epilepsy	N	Y	______/______
Bleeding Disorder	N	Y	______/______
Asthma	N	Y	______/______
Migraine Headaches	N	Y	______/______
Alcoholism	N	Y	______/______
Emphysema	N	Y	______/______
Stomach or Duodenal Ulcer	N	Y	______/______
Kidney Disease	N	Y	______/______
Sickle Cell Anemia	N	Y	______/______
Anemia	N	Y	______/______
Mental Illness	N	Y	______/______
Suicide	N	Y	______/______
Other Serious Disease	N	Y	______/______

	Age	Age at Death
Father		
Mother		
Brothers		
Sisters		
Children		

Reviewed by: Dr. ____________________ Date________________

PERSONAL HISTORY:

How much do you smoke? ____________________ How long have you smoked? ____________

If you smoked in the past, when did you stop? ____

How much alcohol do you drink on the average per day or week? __________________________

Do you use recreational drugs? _________ How much caffeine do you consume in a day? _____

Are you on a special diet? _____ What diet? ____

Have you recently gained or lost weight? Gained? ____________ Lost ____________ N/A _____

Have you ever had a blood transfusion? _____ If yes, give approximate dates ______________

Does your work expose you to: Stress ____ Heavy Lifting ____ Hazardous Substances ____?

OPERATIONS:

Have you had any of the following?

	NO	YES	DATE
Hemorrhoids	____	____	_________
Tonsils	____	____	_________
Appendix	____	____	_________
Gallbladder	____	____	_________
Small Intestine	____	____	_________
Kidney	____	____	_________
Colon	____	____	_________
Thyroid	____	____	_________
Hernia (rupture)	____	____	_________
Stomach	____	____	_________
Breast	____	____	_________
Uterus	____	____	_________
Ovaries	____	____	_________
Prostate	____	____	_________
Other Surgery	____	____	_________

If yes, please name ____

____

Other Hospitalizations	____	____	_________

If yes, please name_________________________________ ____

____

ALLERGIES:

Are you allergic to any of the following?

	NO	YES
Penicillin	____	____
Sulfa	____	____
Other Antibiotics	____	____

If so, please name___________________________

____

____

Any other drug or medicine	____	____

If so, please name ___________________________

____

____

MEDICATIONS:

Please list all medications.

NAME	/STRENGTH	/HOW OFTEN?
________________	/__________	/__________
________________	/__________	/__________
________________	/__________	/__________
________________	/__________	/__________
________________	/__________	/__________
________________	/__________	/__________

Specifically, do you take any of the following over-the-counter supplements?

- METABOLIFE (or equivalent) ☐
- GINKOBA BILOBA
- GINGER ☐
- ST JOHN'S WORT ☐
- GINSENG ☐
- OTHERS ☐

***Dr. INITIAL*________________ *Date*___________**

SYSTEM REVIEW: Do you have any of the following complaints?

GENERAL	**NO**	**YES**
Fever	____	____
General Weakness	____	____
Memory Loss	____	____
Easy Bruising	____	____
Diabetes	____	____

HEAD		
Trouble with Vision	____	____
Trouble with Ears	____	____
Sinus Trouble	____	____
Persistent Hoarseness	____	____
Severe Headaches	____	____
Other______________________	____	____

SKIN		
Changing Mole	____	____
Rash	____	____
Other Skin Problems	____	____

NECK		
Swelling	____	____
Lumps	____	____
Stiffness	____	____
Other_______________________	____	____

CHEST, HEART, LUNGS		
Shortness of Breath	____	____
Poor Exercise Tolerance	____	____
High Blood Pressure	____	____
Fluttering of Heart	____	____
Chest Pain or Pressure Attacks	____	____
Frequent Cough	____	____
Coughing Up Blood	____	____
Wheezing	____	____
Night Sweats	____	____
Swollen Ankles	____	____
Other_____________________	____	____

GASTROINTESTINAL		
Poor Appetite	____	____
Indigestion or Heartburn	____	____
Difficulty Swallowing	____	____
Nausea or Vomiting	____	____
Vomiting Blood	____	____
Abdominal Pain or Cramps	____	____
Abdominal Swelling	____	____
Diarrhea	____	____
Constipation	____	____
Change in Bowel Habits	____	____
Pass Blood from Rectum	____	____
Black, Tar-Like Bowel Movements	____	____
Other_____________________	____	____

KIDNEY	**NO**	**YES**
Kidney Stones	____	____
Blood in Urine	____	____
Pain/Burning while Urinating	____	____
Difficulty Passing Urine	____	____
Difficulty Controlling Urine	____	____
Getting Up at Night to Urinate	____	____
Other _________________	____	____

WOMEN		
Breast Lump	____	____
Discharge from Nipple	____	____
Vaginal Discharge	____	____
Vaginal Bleeding or Spotting (Not with Periods)	____	____
Hot Flashes	____	____
Possibly Pregnant	____	____
Other________________	____	____

MEN		
Prostate Trouble	____	____
Discharge from Penis	____	____
Sore on Penis	____	____
Lump in Testicles	____	____
Difficulty having erections	____	____
Other________________	____	____

NEUROMUSCULAR		
Weakness in Arm or Leg	____	____
Dizzy Spells	____	____
Fainting Spells	____	____
Other________________	____	____

BONES- JOINTS		
Painful Joints	____	____
Swollen Joints	____	____
Loss of Muscle Strength	____	____
Lump or Swelling in Muscle	____	____
Back Pain	____	____
Other_________________	____	____

PSYCHOLOGICAL		
Do you find your life:		
Generally Unsatisfactory	____	____
Boring	____	____
Satisfactory	____	____
Do you:		
Cry Easily	____	____
Feel Anxious or Upset	____	____
Have Difficulty with Sleep	____	____

***Dr. INITIAL*__________________ *Date*____________**