



Current Visit Information

Office Use

This questionnaire collects information about your **current state of health** to assist the medical team with your care and help us meet requirements established by Medicare and other insurers. This information will be stored electronically in your medical record.

Using a black pen, please answer **ALL** questions by filling in the appropriate circle(s) like ●, and by **PRINTING** in the appropriate box.

Patient Information - if any of this information is incorrect, please inform the receptionist.

1	Patient Name: (Last, First, Middle Initial)	Mayo Clinic Number:	Gender:	Date of Birth:
2	Who completed this form? <input type="radio"/> Patient <input type="radio"/> Family Member - Parent, Spouse, Son, Daughter, etc. <input type="radio"/> Domestic Partner <input type="radio"/> Legal Guardian <input type="radio"/> Other			
3	Do you have a living will or other advance directive? <input type="radio"/> Yes, up to date and on file at Mayo Clinic Rochester. <input type="radio"/> No, not interested. <input type="radio"/> Yes, but may need to be updated at Mayo Clinic Rochester. <input type="radio"/> No, but would like more information. <input type="radio"/> I do not know. Additional information is available at the Patient Education Center, or ask the receptionist. (If hospitalized, ask nurse.)			
4	Do you have cultural or religious preferences that you feel we should know about during your care? <input type="radio"/> No <input type="radio"/> Yes			
5	Do you have any special dietary preferences or requirements? <input type="radio"/> No <input type="radio"/> Yes			

Health Care Provider Information

6	Do you have a health care provider outside of Mayo Clinic Rochester? If yes, please fill out the following information and proceed to question 7 on page 2.			
Name of Requesting Provider - the provider outside of Mayo Clinic Rochester who requested or arranged your evaluation at Mayo Clinic.			Date last seen by this provider mm/dd/yyyy	
Street Address		Phone - (area code) and number ()	Fax - (area code) and number ()	
City	State or Province	Country	ZIP Code or Postal Code	
Primary Provider (if different from requesting provider) - the provider outside of Mayo Clinic Rochester who manages your total care or to whom you go for routine health problems.			Date last seen by this provider mm/dd/yyyy	
Street Address		Phone - (area code) and number ()	Fax - (area code) and number ()	
City	State or Province	Country	ZIP Code or Postal Code	

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Continue on Next Page

23623



Allergies

12 Fill in the circle if you have ever had an allergy or sensitivity to each of the following items:

Latex or rubber Betadine or skin disinfectant I have other allergies not listed.
 Specific foods Iodine or X-ray contrast dye No allergy to any of these items
 Influenza (flu) vaccination Other vaccines - Tetanus, Measles, Polio, etc.
 Adhesive tape "-caine" anesthetics such as Xylocaine, Novocaine

13 **List all medications, substances, foods, dusts, fumes, and animals to which you have allergies or unpleasant side effects.**

List Drug or Item	Reaction	List Drug or Item	Reaction
Example: <i>Sulfa</i>	<i>rash</i>		

Systems Review

14 Fill in the circle to the left of each symptom which you wish to call to the attention of your health care provider. Select **No Symptoms** if you have not experienced any of the listed symptoms. Select **Other Symptom(s)** if the symptom you wish to report is not listed.

<input type="radio"/> fevers	<input type="radio"/> sinus congestion	<input type="radio"/> abdominal (belly) pain or cramping
<input type="radio"/> enlarged lymph glands	<input type="radio"/> loss of appetite	<input type="radio"/> pain or stiffness in joints
<input type="radio"/> nipple discharge	<input type="radio"/> coughing up phlegm	<input type="radio"/> joint swelling
<input type="radio"/> breast lump	<input type="radio"/> coughed up blood	<input type="radio"/> muscle pain/stiffness
<input type="radio"/> skin rash/skin sores	<input type="radio"/> swelling in the legs or feet	<input type="radio"/> back pain/stiffness
<input type="radio"/> change in sexual drive or performance	<input type="radio"/> cramping pain in leg muscles when walking	<input type="radio"/> weakness in arms or legs
<input type="radio"/> unusual bruising	<input type="radio"/> chest pain	<input type="radio"/> numbness or shooting pain in hands, arms, legs or feet
<input type="radio"/> change in mole or skin spot	<input type="radio"/> chest pressure	<input type="radio"/> noticed tendency to fall easily
<input type="radio"/> headaches	<input type="radio"/> rapid or fluttering heart beats	<input type="radio"/> weight gain of more than 10 pounds
<input type="radio"/> seizures	<input type="radio"/> difficulty swallowing	<input type="radio"/> weight loss of more than 10 pounds
<input type="radio"/> slurred speech	<input type="radio"/> heartburn	<input type="radio"/> heavy snoring
<input type="radio"/> unusual thirst	<input type="radio"/> nausea and/or vomiting	<input type="radio"/> sleep difficulty
<input type="radio"/> hoarseness	<input type="radio"/> constipation	<input type="radio"/> excessive daytime drowsiness
<input type="radio"/> double vision	<input type="radio"/> diarrhea	<input type="radio"/> irregular breathing during sleep
<input type="radio"/> sudden loss of vision	<input type="radio"/> blood in stool	<input type="radio"/> felt sad most of the time
<input type="radio"/> vision problems	<input type="radio"/> changes in your stool characteristics	<input type="radio"/> felt restless or irritable
<input type="radio"/> shortness of breath	<input type="radio"/> frequent urination	<input type="radio"/> felt anxious or nervous
<input type="radio"/> coughing	<input type="radio"/> burning or painful urination	<input type="radio"/> had little interest or pleasure in relationships, or activities
<input type="radio"/> wheezing	<input type="radio"/> difficulty starting urination	<input type="radio"/> had difficulty concentrating
<input type="radio"/> "black outs" or loss of consciousness	<input type="radio"/> uncontrolled urge to urinate	<input type="radio"/> had recurring thoughts of death or suicide
<input type="radio"/> awakened with shortness of breath	<input type="radio"/> blood in urine	<input type="radio"/> Other symptom(s) not listed
<input type="radio"/> hearing loss	<input type="radio"/> leaking urine	<input type="radio"/> No symptoms
<input type="radio"/> light-headedness	<input type="radio"/> fatigue	

Continue on Next Page

23623



Systems Review, continued

15	Are you having difficulty with pain?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know
16	Have you had the following immunizations:			
	Pneumococcal (for pneumonia)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know
	Tetanus/Diphtheria within the last 10 years?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know
	Influenza shot within the last 12 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know
17	Have you ever had a colon or rectum examination?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know
	If yes, how long ago was it?	<input type="radio"/> Less than 1 year	<input type="radio"/> 1-3 years	<input type="radio"/> 4-5 years
18	Do you feel you might be at risk for HIV or AIDS?	<input type="radio"/> No	<input type="radio"/> Yes	
19	Have you ever had tuberculosis (TB) or had exposure to someone who had TB?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know
20	Do you have a communicable infectious disease (such as hepatitis)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Don't know

► Questions 21-31 are to be completed for FEMALE patients ONLY.

21	How long has it been since your last PAP smear and pelvic exam? <input type="radio"/> Less than 1 year <input type="radio"/> 1 to 2 years <input type="radio"/> More than 2 years <input type="radio"/> Don't know <input type="radio"/> Never had a PAP smear	26	Might you be pregnant at this time? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
		27	Are you currently breast-feeding? <input type="radio"/> No <input type="radio"/> Yes
22	Have you EVER had an abnormal PAP smear? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know	28	Have your menstrual periods changed in any way or become abnormal to you? <input type="radio"/> No <input type="radio"/> No, I am past menopause <input type="radio"/> No, I have had a hysterectomy <input type="radio"/> Yes
23	How long has it been since your last mammogram? <input type="radio"/> Less than 1 year <input type="radio"/> 1 to 2 years <input type="radio"/> More than 2 years <input type="radio"/> Don't know <input type="radio"/> Never had a mammogram		
24	How many pregnancies have you had? 0 1 2 3 4 5 6 7 8 9+ <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	29	Are you experiencing unusual vaginal bleeding? <input type="radio"/> No <input type="radio"/> Yes
25	How many live births have you delivered? 0 1 2 3 4 5 6 7 8 9+ <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	30	Have you had a tubal ligation? <input type="radio"/> No <input type="radio"/> Yes
		31	Date of onset of your last menstrual period mm/dd/yyyy :

► Questions 32-34 to be completed by MALE patients ONLY.

32	How long has it been since your last prostate exam? <input type="radio"/> Less than 1 year <input type="radio"/> 1 to 2 years <input type="radio"/> More than 2 years <input type="radio"/> Don't know <input type="radio"/> Never had a prostate exam	33	Have you EVER had an abnormal prostate exam? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
		34	Have you had a vasectomy? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know

Continue on Next Page

23623



Social Context

35	Select the highest level of schooling you have completed: <input type="radio"/> 8th grade or less <input type="radio"/> Some high school, but didn't graduate <input type="radio"/> High school graduate or GED <input type="radio"/> Some college or 2-year degree <input type="radio"/> 4-year college graduate <input type="radio"/> Post graduate studies
36	What is your current employment status? <input type="radio"/> Employed <input type="radio"/> Unemployed <input type="radio"/> Work disabled <input type="radio"/> Student <input type="radio"/> Retired <input type="radio"/> Self-employed <input type="radio"/> Full-time homemaker <input type="radio"/> Other
37	List most recent occupation: _____
38	What is your current relationship status? <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Single <input type="radio"/> Widowed <input type="radio"/> Committed relationship <input type="radio"/> Other
39	Has your relationship status changed in the past 12 months? <input type="radio"/> No <input type="radio"/> Yes
40	Do you ever feel afraid in your home? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know Are you ever fearful for your own safety? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know

Substance Use History

41	Have you ever felt the need to cut down on your alcohol consumption? <input type="radio"/> No <input type="radio"/> Yes
42	Do relatives/friends worry or complain about your alcohol consumption? <input type="radio"/> No <input type="radio"/> Yes
43	Do you currently smoke or use other tobacco products? <input type="radio"/> No, never used any <input type="radio"/> No, I quit all use <input type="radio"/> Yes → If yes, mark all that apply: <input type="radio"/> Cigarettes <input type="radio"/> Pipe <input type="radio"/> Cigar <input type="radio"/> Chewing tobacco <input type="radio"/> Other
44	If you previously smoked or used other tobacco products and have quit, how long ago did you quit? <input type="radio"/> Within the past 30 days <input type="radio"/> 1-12 months ago <input type="radio"/> 2-3 years ago <input type="radio"/> 4-10 years ago <input type="radio"/> 11 or more years ago
45	If you do smoke or use other tobacco products, how motivated are you to quit? <input type="radio"/> Not motivated <input type="radio"/> Somewhat motivated <input type="radio"/> Very motivated

Self-Care / Home Environment Assessment

46	Can you climb two flights of stairs without stopping to rest? <input type="radio"/> Yes, with no difficulty <input type="radio"/> Yes, with difficulty <input type="radio"/> No, can't do at all <input type="radio"/> Don't know
47	Are you dependent on a device for normal breathing (CPAP, nasal oxygen)? <input type="radio"/> No <input type="radio"/> Yes
48	Fill in the circle to the left of each activity which you have difficulty performing on your own? <input type="radio"/> Preparing meals <input type="radio"/> Using the toilet <input type="radio"/> Bathing <input type="radio"/> Getting in and out of bed <input type="radio"/> Feeding yourself <input type="radio"/> Housekeeping <input type="radio"/> Walking <input type="radio"/> Managing medications <input type="radio"/> Dressing <input type="radio"/> Climbing stairs <input type="radio"/> Using transportation <input type="radio"/> No difficulty with any of these activities
49	Which of the following describes your living environment? <input type="radio"/> House <input type="radio"/> Apartment <input type="radio"/> Assisted Living <input type="radio"/> Nursing Home <input type="radio"/> Other
50	With whom do you live? <input type="radio"/> Live alone <input type="radio"/> Spouse <input type="radio"/> Domestic partner <input type="radio"/> Family <input type="radio"/> Other
51	Do you have assistance for your home care from family, friends, or others should you require it? <input type="radio"/> No <input type="radio"/> Yes
52	Do you depend on any assistive devices such as a cane, wheelchair, braces, walker, or assistance from other people to perform activities important to you in your daily life? <input type="radio"/> No <input type="radio"/> Yes
53	Do you wear dentures? <input type="radio"/> No <input type="radio"/> Yes
54	Do you have hearing aid(s)? <input type="radio"/> No <input type="radio"/> Yes

See the instruction page for information about returning this form.

23623

