

CURRENT VISIT INFORMATION

ISJ Clinic – NorthRidge

Mayo Health System

1695 LorRay Drive, North Mankato, MN 56003

Phone: 507-385-5700 Fax: 507-387-5701

PATIENT PROVIDED INFORMATION

The information you provide us will greatly help us to provide the highest quality and comprehensive care for you.

Date of birth _____ Phone _____ Religion _____

1. Do you have a living will or other advance directive? No, not interested No, would like more information
 Yes ☞ If new or changed, please bring to your appointment

A. HEALTHCARE PROVIDER INFORMATION (Speciality Clinic Visit Only)

2. Do you want us to send this to your healthcare provider? No Yes

Name/Title _____ Phone _____

Address _____

B. MEDICATIONS

3. Please list any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal therapy and cold medications you are currently taking.

I am not taking any medications

Name of Medication	Dose (Strength)	How Often Taken (e.g. 12x per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking more medications than space provided? No Yes

Have you taken aspirin-containing products in the last two weeks? No Yes

Have you taken steroid or cortisone-type drugs within the last year? No Yes

Are there any other medications you have used in the past month and are no longer taking? No Yes

Do you take antibiotics prior to dental work or any other procedure? No Yes

C. ALLERGIES

4. Are there medications to which you have had an allergic reaction or unpleasant side-effects? Yes ☞ If yes, please describe in the space below. If more than space allows, bring a list to your appointment. None

Name of Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you had an allergic reaction to any of the following? Latex or rubber Bee or wasp stings Adhesive tape
 Iodine or x-ray contrast dye Influenza vaccination Other ☞ Discuss with your care provider None

Do you have any food allergies? If yes, bring a list with you to your appointment. None

D. SYSTEM REVIEW

5. Check the square to the left of each symptom that you have experienced in the past few months. Indicate "None" (at the end of the list) if you have not experienced any of the symptoms listed in each group. **In the past few months, have you had:**

GENERAL

- Weight gain
- Weight loss
- Fever in past month
- Chills
- Sweats
- Fatigue

- Double vision
- Eye pain
- Sinus problems
- Hoarseness
- Difficulty swallowing
- Mouth sores
- Diminished hearing

PULMONARY (Lungs/breathing)

- Shortness of breath
- Coughing
- Wheezing
- Coughed up sputum
- Coughed up blood

CARDIAC (Heart)

- Known difficulty with heart valve
- Chest pain

EENT (Eyes/ears/nose/throat)

- Blurred vision
- Ringing in ears
- Enlarged glands (Lymph nodes)

(Label)

Patient Name _____ DOB _____ Unit No. _____

D. SYSTEM REVIEW (Continued)

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pressure | <input type="checkbox"/> Changes in bowel movements | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Rapid heart beats | REPRODUCTIVE | <input type="checkbox"/> Muscle stiffness |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Difficulty moving arms and legs | <input type="checkbox"/> Sexual preference: male, female, both | <input type="checkbox"/> Back stiffness |
| <input type="checkbox"/> Abnormal swelling in legs or feet | <input type="checkbox"/> Vaginal bleeding | INTEGUMENTARY (Skin) |
| <input type="checkbox"/> Pain in calves or your legs when walking | <input type="checkbox"/> Change in sexual drive or performance | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Nipple discharge | G.U. (Bladder/kidney) | <input type="checkbox"/> Skin sores |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Penile discharge | <input type="checkbox"/> Change in mole |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Burning/pain when urinating | NEUROLOGICAL (Brain/nerves) |
| <input type="checkbox"/> Breast changes | <input type="checkbox"/> Difficulty starting urinary stream | <input type="checkbox"/> Significant headaches |
| G.I. (Stomach/colon) | <input type="checkbox"/> Difficulty completely emptying bladder | <input type="checkbox"/> Slurred speech |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Difficulty with leaking urine from bladder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> "Blacked out" or lost consciousness |
| <input type="checkbox"/> Stomach trouble | MUSCULOSKELETAL (Muscles/joints) | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Joint pain | ENDOCRINE |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Blood in bowel movements (Stool) | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Excessive bruising |

We are concerned about your emotional health as well.

6. Have you been: Physically abused Sexually abused Emotionally abused Do not know None
7. Do you feel depressed or blue or anxious? No Yes
8. Do you have trouble falling or staying asleep? No Yes
9. Are you awakened at night with shortness of breath? No Yes

10. Have you had the following immunizations: Tetanus/Diphtheria within the last ten years? _____
 Influenza within the past year? _____

11. Have you ever had an x-ray or instrument examination of the colon or rectum (Proctoscopy, sigmoidoscopy, colonoscopy)? _____

If yes, how long ago was your last examination? _____

12. How would you rate your stress level? (1 = the lowest and 5 = the highest) _____

13. Are you concerned about your risk for HIV or AIDS? _____ Other infectious diseases? _____

14. Have you ever felt the need to cut down on your alcohol consumption? _____

15. Do relatives/friends worry or complain about your alcohol consumption? _____

Questions 16-25 to be completed by FEMALE patients ONLY.

16. How long has it been since your last Pap smear and pelvic exam? Less than one year 1-2 years 2-3 years
 Over three years Never

17. Have you **ever** had an abnormal pap smear? _____

CURRENT VISIT INFORMATION

(Label)

Patient Name _____ DOB _____ Unit No. _____

D. SYSTEM REVIEW (Continued)

- 18. Have you had a hysterectomy? _____
- 19. How long has it been since your last mammogram? _____
- 20. Number of : Pregnancies: _____
Live births: _____
- 21. Have you experienced menopause? _____
- 22. Are you concerned about your menstrual periods? No Yes
- 23. Might you be pregnant at this time? No Yes
- 24. Date of onset of your last menstrual period: Mo/Day/Yr _____ Was it normal? _____
- 25. Have you had a bone density exam? No Yes If Yes, when _____

Questions 26-29 to be completed by MALE patients ONLY.

- 26. How long has it been since your last prostate exam? Less than one year 1-2 years Over two years Never
- 27. Have you **ever** had an abnormal prostate exam? _____
- 28. Have you had a vasectomy? _____
- 29. Have you experienced erectile dysfunction _____

E. SOCIAL HISTORY

- 30. What are your current living arrangements? _____
- 31. Do you live: Alone With spouse/family With others _____
- 32. Do you have family/friends or others who are able to provide assistance with your homecare needs if you would ever require such assistance? _____
- 33. How many years of school have you completed? Record the highest level attained. _____
- 34. Are you currently married? No Yes If yes, indicate your spouse's current employment status. _____
- 35. Have you been: Divorced Widow/Widower In the past year? _____
- 36. What is your current employment status? _____
- 37. Are you disabled? _____

F. SUBSTANCE REVIEW

38. Alcohol	Number of Days Per Week	Number of Servings Per Day	Number of Years Used
Current Use	<input type="checkbox"/> 0-2 <input type="checkbox"/> 3-7	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-10+	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10 <input type="checkbox"/> 10+ <input type="checkbox"/> None

39. Caffeine	Number of Servings Per Day
Current Use	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-10+ <input type="checkbox"/> None

40. Cigarettes/Pipe/Cigar	Number of Packs Per Day	Number of Years Used
Current Use	<input type="checkbox"/> None <input type="checkbox"/> 0-1/2 <input type="checkbox"/> 1/2-1 <input type="checkbox"/> 1-1 1/2 <input type="checkbox"/> 2 <input type="checkbox"/> 2+	<input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-15 <input type="checkbox"/> 16-30 <input type="checkbox"/> 30+
Previous Use	<input type="checkbox"/> None <input type="checkbox"/> 0-1/2 <input type="checkbox"/> 1/2-1 <input type="checkbox"/> 1-1 1/2 <input type="checkbox"/> 2 <input type="checkbox"/> 2+	<input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-15 <input type="checkbox"/> 16-30 <input type="checkbox"/> 30+

Other Tobacco	Number of Years Used
41. Smokeless/Chew/Snuff	<input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-15 <input type="checkbox"/> 16-30 <input type="checkbox"/> 30+ <input type="checkbox"/> None

42. Recreational Street drug use _____ None

G. UPDATE: PAST MEDICAL HISTORY

43. Have you had any hospitalizations, surgeries in the past one to two years? No Yes If Yes, what was the problem? _____
When? _____

H. SELF - CARE / HOME ENVIRONMENT ASSESSMENT

- 44. In an average week, how many minutes of moderately vigorous or vigorous physical activity do you get?
 0-1/2 hr 1/2-1 hr 1-2 hrs 2-3 hrs 3-4 hrs 4-5 hrs 5+ hrs None
- 45. Do you have difficulty performing these activities by yourself? Check all that apply. Indicate "None" if you are able to perform all of these activities by yourself. Eating Bathing Dressing Walking Using the toilet Transportation
 Housekeeping Taking medications Climbing the stairs None
- 46. Do you have any special dietary needs? No Yes

(Label)

Patient Name _____ DOB _____ Unit No. _____

H. SELF - CARE / HOME ENVIRONMENT ASSESSMENT (Continued)

47. Do you wear dentures? Specify _____

48. How many servings of fruits and/or vegetables do you have in an average day? 0-1 2 3 4 5 6+

49. Do you have guns in the home? No Yes

50. Do you have smoke detectors in your home? No Yes

(Signature of Person Completing Form)

(How Related)

(Date)

(Signature of Provider)

(Reviewed/Dated)

Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____
Signature of Provider _____	Reviewed/Updated _____