Current Visit Form

MR#:_____ Date:_____
Name:_____
DOB:_____ Gender: □ Male □ Female

Who completed this form? □ Self □ Parent □ Spouse/Family Member □ Guardian □ Other

1. Health Care Provider Information

Name of requesting provider: Date last seen by this provider:

_____

Street Address: Phone (area code) and number Fax number:

_____

City: State: Zip code:

_____

2. Medications and Supplements

Name of Medication and supplement	Strength of each dose	Number of doses at a time	Frequency

CONTINUE ON REVERSE SIDE

Allergies

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

- ☐ Latex or rubber
- ☐ Specific foods
- ☐ Influenza (flu) vaccination
- ☐ Adhesive tape
- ☐ Betadine or skin disinfectant
- ☐ Iodine or X-ray contrast dye
- ☐ Other vaccines- Tetanus, etc.
- ☐ Anesthetics
- ☐ I have other allergies not listed
- ☐ No allergy to any of these items

3. List all medications, substances, foods, dusts, and animal to which you have an allergy or unpleasant side effect.

List drug or item:	Reaction:		List drug or item:	Reaction:

4. Self-Care/ Home Environment

Can you climb two flights of stairs without stopping to rest?
☐ Yes, with no difficulty ☐ Yes, with difficulty ☐ No, can't do at all ☐ Don't know

Are you dependent on a device for normal breathing (Nasal oxygen, CPAP)? ☐ No ☐ Yes

Are you dependent on a gait-aid device or wheelchair?
☐ No, I walk independently ☐ Yes, walker ☐ Yes, cane ☐ Yes, wheelchair ☐ Don't know

Check the box to the left of each activity which you have difficulty performing on your own:
☐ Preparing meals ☐ Using toilet ☐ Bathing ☐ Getting in and out of bed
☐ Feeding yourself ☐ Housekeeping ☐ Walking ☐ Managing medications
☐ Dressing ☐ Using transportation ☐ No difficulty with any of these items

Which of the following describes your living environment?
☐ House ☐ Apartment ☐ Assisted Living ☐ Nursing Home ☐ Other

With whom do you live?
☐ Live alone ☐ Spouse ☐ Domestic partner ☐ Family ☐ Other

Do you have assistance for your home care from family, friends, or others should you require it?
☐ No ☐ Yes

Do you wear hearing aids? ☐ No ☐ Yes

Do you have a living will or advance directive? ☐ No ☐ Yes

Do you have cultural or religious preferences that you feel we should know about during your care? ☐ No ☐ Yes

Patient Signature_____ Date:_____

Physician Signature_____Date:_____
Read and reviewed with patient in detail

The Movement Disorder Clinic of Oklahoma Kevin J. Klos, MD

Current Visit Form – Part II

Social History
Have you ever traveled or lived outside of the United States? □ Don't know □ No □ Yes
Have you ever received a blood transfusion? □ Don't know □ No □ Yes
Select the highest level of schooling you have completed: □ 8th Grade or less □ Some high school, but didn't graduate □ High school graduate or GED □ Some college or 2-year degree □ 4-year college graduate □ Post graduate studies
What is your current employment status? □ Employed □ Unemployed □ Work disabled □ Student □ Retired □ Self-employed □ Full-time homemaker □ Other
List most recent occupation:
What is your current relationship status? □ Married □ Divorced □ Separated □ Single □ Widowed □ Other
Has your relationship status changed in the last 12 months? □ No □ Yes
Do you ever feel afraid in your home? □ Don't know □ No □ Yes Are you ever fearful for your own safety? □ Don't know □ No □ Yes
Have you ever felt the need to cut down on your alcohol consumption? □ No □ Yes
Do relatives/friends worry or complain about your alcohol consumption? □ No □ Yes
Do you currently smoke or use other tobacco products? □ No, never used any □ No, quit all □ Yes → If yes, mark all that apply: □ Cigarettes □ Pipe □ Cigar □ Chewing tobacco
If you previously used tobacco products and have quit, how long ago did you quit? □ Within the past 30 days □ 1-12 months ago □ 2-3 years ago □ 4-10 years ago □ 11 or more years ago
Have you ever used any recreational or street drugs? □ No □ Yes

CONTINUE ON REVERSE SIDE

Review of Systems

Check each box 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.

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

Are you having difficulty with pain? □ No □ Yes □ Don't know

Have you ever had a colon or rectum examination? □ No □ Yes □ Don't know

Do you feel you might be at risk for HIV or AIDS? □ No □ Yes □ Don't know

Have you ever had tuberculosis (TB) or had exposure to someone who had TB?
□ No □ Yes □ Don't know

Do you have a communicable infectious disease (such as hepatitis)?
□ No □ Yes □ Don't know

Females Patients ONLY:
Might you be pregnant at this time? □ No □ Yes □ Don't know

Patient Signature_____ Date:_____

Physician Signature_____Date:_____

Read and reviewed with patient in detail

The Movement Disorder Clinic of Oklahoma, Inc. Kevin J. Klos, MD