Current Visit Form				
MR#: Name: DOB:				e: der: □ Male □ Female
Who completed this form?  Self  H	Parent	Spouse/Family	Member 🗆 Guardia	n 🗆 Other
<b>1. Health Care Provider Information</b> Name of requesting provider:	on		Date last seer	n by this provider:
Street Address:		Phone (area co	ode) and number	Fax number:
City:	State:	Z	ip code:	
<b>2. Medications and Supplements</b> Name of Medication and supplement		Strength of each dose	Number of doses at a time	Frequency

CONTINUE ON REVERSE SIDE

A	11	ergies
		CIGICO

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

- $\Box$  Latex or rubber □ Betadine or skin disinfectant
- $\Box$  Specific foods
- □ Influenza (flu) vaccination  $\Box$  Other vaccines- Tetanus, etc.  $\Box$  Adhesive tape

allergies not listed  $\Box$  Iodine or X-ray contrast dye  $\Box$  No allergy to

any of these items

 $\Box$  I have other

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

□ Anesthetics

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?				
$\Box$ Yes, with no difficulty $\Box$ Yes, with difficulty $\Box$ No, can't do at all $\Box$ 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?				
$\Box Live alone \Box Spouse \Box Domestic partner \Box Family \Box Other$				
Do you have assistance for your home care from family, friends, or others should you require it?				
$\Box$ No $\Box$ Yes				
Do you wear hearing aids? $\Box$ No $\Box$ Yes				
Do you have a living will or advance directive?				
Do you have cultural or religious preferences that you feel we should know about during your				
care? $\Box$ No $\Box$ Yes				
Patient Signature Date:				
Physician SignatureDate:				
Read and reviewed with patient in detail				
x x				

The Movement Disorder Clinic of Oklahoma

## **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? $\Box$ Don't know $\Box$ No $\Box$ Yes				
Select the highest level of schooling you have completed:				
$\Box$ 8 <sup>th</sup> Grade or less $\Box$ 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? $\Box$ No $\Box$ Yes				
Do you ever feel afraid in your home? $\Box$ Don't know $\Box$ No $\Box$ Yes				
Are you ever fearful for your own safety?				
Have you ever felt the need to cut down on your alcohol consumption? $\Box$ No $\Box$ Yes				
Do relatives/friends worry or complain about your alcohol consumption?				
Do you currently smoke or use other tobacco products? $\Box$ No, never used any $\Box$ No, quit all				
$\Box$ Yes $\rightarrow$ If yes, mark all that apply: $\Box$ Cigarettes $\Box$ Pipe $\Box$ Cigar $\Box$ Chewing tobacco				
If you previously used tobacco products and have quit, how long ago did you quit?				
$\Box$ Within the past 30 days $\Box$ 1-12 months ago $\Box$ 2-3 years ago				
$\Box$ 4-10 years ago $\Box$ 11 or more years ago				
Have you ever used any recreational or street drugs? $\Box$ No $\Box$ Yes				

## **CONTINUE ON REVERSE SIDE**

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.         Forest	Review of Systems				
e       fifeulty swallowing       headaches         e       nalarged lymph glands       heatrburn       seizures         loss of appetite       nausea and/or vomiting       slurred speech         weight gain (>10 pounds)       constipation       hoarseness         weight loss (>10 pounds)       diarrhea       double vision         sweling in legs or feet       blood in stool       back pain/stiffness         chest pain       abdominal pain or cramping       weakeness in arms or legs         chest pressure       frequent urination       numbness or shooting pain         awakened with shortness of       burning or painful urination       tendency to fall easily         breath       mucontrolled urge to urinate       heavy snoring         coughing up phlegm       nipple discharge       excessive daytime drowsiness         coughing up phlegm       bhoage in sexual       recurring thoughts of death or suicide         sinus congestion       change in sexual       recurring thoughts of death or suicide         pain swelling       unusual thrist       little interest in         light-headedness       vision problems       etationships or activities         black outs"       No       Yes       Don't know         Are you having difficulty with pain?       No	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				
enlarged lymph glands       heartburn       seizures         loss of appetite       nausea and/or vomiting       slurred speech         weight gain (>10 pounds)       constipation       hoarseness         weight gain (>10 pounds)       diarrhea       double vision         fatigue       changes in stool characteristics       sudden loss of vision         chest pressure       blood in stool       back pain/stiffness         chest pressure       frequent urination       numbness or shooting pain         awakened with shortness of       burning or painful urination       numbness or shooting pain         raad cong pain when walking       blood in urine       muscle pain/stiffness         coughing up phlegm       nipple discharge       excessive daytime drowsiness         coughing       skin rash / skin sores       felt axitous or nervous         wheezing       change in mole or skin spot       felt restless or irritable         isinus congestion       change in sexual       recurring thoughts of death or suicide         ight-headedness       vision problems       difficulty concentrating         ight-headedness       vision problems       difficulty concentrating         op or terum waintation?       No       Yes       Don't know         Are you having difficulty with pain?					
Image: Instant Structure       Image: I					
weight gain (>10 pounds)         constipation         hoarseness           weight loss (>10 pounds)         diarthea         double vision           stigue         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           waxkened with shortness of         burning or painful urination         endency to fall easily           regular breath         uncontrolled urge to urinate         muscle pain/stiffness           coughing up phlegm         laking urine         irregular breathing in sleep           coughing         skin rash/skin sores         felt axious or nervous           shortness of breath         unusual bruising         felt axious or nervous           shortness         change in mole or skin spot         felt axious or nervous           gain or stiffness         ounsual bruising         felt axious or nervous           ingth-headedness         orive/performance         suide         suide           ingth-headedness         vision problems         difficulty concentrating         other symptoms not listed           back outs''					
weight loss (>10 pounds)       diarrhea       double vision         fatigue       changes in stool characteristics       sudden loss of vision         swelling in legs or feet       blood in stool       blood in stool         chest pain       abdominal pain or cramping       weakness in arms or legs         chest pressure       frequent urination       numbness or shooting pain         awakened with shortness of       burning or painful urination       numbness or shooting pain         breath       uncontrolled urge to urinate       heavy snoring         cramping pain when walking       blood in urine       heavy snoring         radid or fluttering heart beats       leaking urine       irregular breathing in sleep         coughing up phlegm       nipple discharge       excessive daytime drowsiness         coughing       skin rash/skin sores       felt sad most of the time         shortness of breath       change in sexual       felt restless or irritable         sint congestion       change in sexual       recurring thoughts of death or suicide         gint weeling       unusual thirst       little interest in         light-headedness       vision problems       difficulty concentrating         other symptoms not listed       No symptoms       No symptoms         Dyou have a communicable in			1		
☐ 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       □ burning or painful urination       □ tendency to fall easily         □ awakened with shortness of       □ burning or painful urination       □ tendency to fall easily         □ reath       □ uncontrolled urge to urinate       □ heavy snoring         □ rapid or fluttering heart beats       □ leaking urine       □ irregular breathing in sleep         □ coughing up phlegm       □ nipple discharge       □ excessive daytime drowsiness         □ coughing       □ skin rash/ skin sores       □ felt anxious or nervous         □ sinus congestion       □ change in mole or skin spot       □ felt restless or irritable         □ sinus welling       □ unusual thirst       □ little interest in       □ recurring thoughts of death or suicide         □ pain or stiffness in joints       □ unusual thirst       □ little interest in       □ relationships or activities         □ black outs"       □ hearing loss       □ difficulty concentrating       □ other symptoms not listed         □ by ou					
swelling in legs or feet       blood in stool       back pain/stiffness         chest pain       abdominal pain or cramping       mumbness or shooting pain         awakened with shortness of       burning or painful urination       mumbness or shooting pain         breath       uncontrolled urge to urinate       muscle pain/stiffness         caupping pain when walking       blood in urine       muscle pain/stiffness         caupping pain when walking       blood in urine       muscle pain/stiffness         coughing up phlegm       nipple discharge       excessive daytime drowsiness         coughing up blood       breast lump       sleep difficulty         coughing       skin rash/skin sores       felt anxious or nervous         shortness of breath       change in mole or skin spot       felt restless or irritable         joint swelling       change in sexual       recurring thoughts of death or suicide         joint swelling       unusual thirst       little interest in relationships or activities         'black outs''       hearing loss       difficulty concentrating         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         Have you ever had t colon or rectum examination?       No <td><b>U</b></td> <td></td> <td></td>	<b>U</b>				
chest pain       abdominal pain or cramping       weakness in arms or legs         chest pressure       frequent urination       numbness or shooting pain         awakened with shortness of       burning or painful urination       tendency to fall easily         cramping pain when walking       blood in urine       muscle pain/stiffness         crauping pain when walking       blood in urine       heavy snoring         coughing up phlegm       blood       irregular breathing in sleep         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         shortness of breath       change in sexual       recurring thoughts of death or         joint swelling       unusual thrist       little interest in         light-headedness       vision problems       relationships or activities         'black outs''       No       Yes       Don't know         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         No       Yes       Don't know       Don't know       No symptoms	-				
chest pressure       frequent urination       numbness or shooting pain         awakened with shortness of       burning or painful urination       tendency to fall easily         breath       uncontrolled urge to urinate       muscle pain/stiffness         cramping pain when walking       blood in urine       heavy snoring         coughing up phlegm       leaking urine       lerequent drowsiness         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 anxious or nervous         pain or stiffness in joints       unusual bruising       felt restless or irritable         light-headedness       vision problems       little interest in         wision problems       difficulty concentrating       other symptoms not listed         No       Yes       Don't know         Have you ever had a colon or rectum examination?       No       Yes       Don't know         Have you ever had tuberculosis (TB) or had exposure to someone who had TB?       No       Yes       Don't know         No       Yes       Don't know       No       Yes       Don't know			-		
awakened with shortness of breath       burning or painful urination       chednecy to fall easily         cramping pain when walking       blood in urine       muscle pain/stiffness         cramping pain when walking       blood in urine       heavy snoring         craupid or fluttering heart beats       leaking urine       irregular breathing in sleep         coughing up phlegm       nipple discharge       excessive daytime drowsiness         coughing       skin rash/ skin sores       felt sad most of the time         shortness of breath       change in mole or skin spot       felt sad most of the time         shortness of breath       change in sexual       recurring thoughts of death or suicide       suicide         pain or stiffness in joints       unusual bruisng       little interest in relationships or activities       little interest in relationships or activities         'black outs''       hearing loss       difficulty concentrating         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         No       Yes       Don't know       Have you ever had tuberculosis (TB) or had exposure to someone who had TB?         No       Yes       Don't know	*		e		
breath       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         coughing       skin rash/ skin sores       elts ad most of the time         shortness of breath       change in mole or skin spot       felt sad most of the time         shortness of breath       change in sexual       recurring thoughts of death or         sinus congestion       change in sexual       recurring thoughts of death or         joint swelling       unusual thirst       little interest in         light-headedness       vision problems       little interest in         'black outs''       hearing loss       difficulty concentrating         other symptoms not listed       No symptoms       No symptoms         Do you feel you might be at risk for HIV or AIDS?       No       Yes       Don't know         Do you have a communicable infectious disease (such as hepatitis)?       No       Yes       Don't know	<b>▲</b>	-	• •		
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         coughing       skin rash/ skin sores       sleep difficulty         coughing       skin rash/ skin sores       felt sad most of the time         shortness of breath       change in mole or skin spot       felt restless or irritable         sinus congestion       change in sexual       recurring thoughts of death or         sijoint swelling       drive/performance       suicide         pain or stiffness in joints       unusual thirst       little interest in         light-headedness       vision problems       difficulty concentrating         'black outs''       hearing loss       difficulty concentrating         Are you having difficulty with pain?       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 <td><math>\Box</math> awakened with shortness of</td> <td>□ burning or painful urination</td> <td><math>\Box</math> tendency to fall easily</td>	$\Box$ awakened with shortness of	□ burning or painful urination	$\Box$ tendency to fall easily		
arapid or fluttering heart beats       aleaking 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       aunusual bruising       felt restless or irritable         sinus congestion       change in sexual       recurring thoughts of death or suicide         joint swelling       drive/performance       suicide         pain or stiffness in joints       unusual thirst       little interest in relationships or activities         'fblack outs''       hearing loss       difficulty concentrating         other symptoms not listed       No symptoms       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         Mo       Yes       Don't know       Yes       Don't know         Do you feel you might be at risk for HIV or AIDS?       No       Yes       Don't know         No       Yes       Don't know       Yes       <	breath	□ uncontrolled urge to urinate	□ muscle pain/stiffness		
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       recurring thoughts of death or suicide         joint swelling       drive/performance       suicide         light-headedness       vision problems       little interest in relationships or activities         'black outs''       hearing loss       difficulty concentrating         Are you having difficulty with pain?       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?       Don't know         No       Yes       Don't know       Don't know		$\Box$ blood in urine	$\Box$ heavy snoring		
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       recurring thoughts of death or suicide         joint swelling       unusual thirst       little interest in         light-headedness       vision problems       difficulty concentrating         ''black outs''       hearing loss       difficulty concentrating         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         No       Yes       Don't know       Doy ou have a communicable infectious disease (such as hepatitis)?       No       Yes       Don't know	$\Box$ rapid or fluttering heart beats	$\Box$ leaking urine	$\Box$ irregular breathing in sleep		
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       recurring thoughts of death or suicide         pain or stiffness in joints       unusual thirst       little interest in         light-headedness       vision problems       little interest in         'black outs''       hearing loss       difficulty concentrating         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         Have you ever had tuberculosis (TB) or had exposure to someone who had TB?       No       Yes       Don't know         No       Yes       Don't know       Doy ou have a communicable infectious disease (such as hepatitis)?       No       Yes       Don't know	$\Box$ coughing up phlegm	□ nipple discharge	$\Box$ excessive daytime drowsiness		
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       recurring thoughts of death or suicide         pain or stiffness in joints       unusual thirst       Itile interest in relationships or activities         ight-headedness       vision problems       difficulty concentrating         "black outs"       hearing loss       difficulty concentrating         Other symptoms not listed       No symptoms       No symptoms         Have you ever had a colon or rectum examination?       No       Yes       Don't know         Have you ever had tuberculosis (TB) or had exposure to someone who had TB?       No       Yes       Don't know         No       Yes       Don't know       No       Yes       Don't know	$\Box$ coughed up blood	□ breast lump	□ sleep difficulty		
wheezing       unusual bruising       felt restless or irritable         sinus congestion       change in sexual       recurring thoughts of death or suicide         pain or stiffness in joints       unusual thirst       little interest in relationships or activities         light-headedness       vision problems       difficulty concentrating         "black outs"       hearing loss       difficulty concentrating         Other symptoms not listed       No symptoms       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         No       Yes       Don't know       TB?         No       Yes       Don't know       No         No       Yes       Don't know	$\Box$ coughing	□ skin rash/ skin sores	$\Box$ felt sad most of the time		
Image: sinus congestion       Image: change in sexual       Image: recurring thoughts of death or suicide         Image: pain or stiffness in joints       Image: unusual thirst       Image: list in list image: lis	$\Box$ shortness of breath	$\Box$ change in mole or skin spot	$\Box$ felt anxious or nervous		
i joint swelling       drive/performance       suicide         pain or stiffness in joints       unusual thirst       little interest in         light-headedness       vision problems       relationships or activities         "black outs"       hearing loss       difficulty concentrating         other symptoms not listed       No symptoms         Are you having difficulty with pain?       No       Yes         Are you ever had a colon or rectum examination?       No       Yes         Do you feel you might be at risk for HIV or AIDS?       No       Yes         No       Yes       Don't know         Do you have a communicable infectious disease (such as hepatitis)?       No       Yes         No       Yes       Don't know	□ wheezing	□ unusual bruising	$\Box$ felt restless or irritable		
pain or stiffness in joints       unusual thirst       little interest in         light-headedness       vision problems       relationships or activities         ''black outs''       hearing loss       difficulty concentrating         other symptoms not listed       No symptoms         Are you having difficulty with pain?       No       Yes         Are you ever had a colon or rectum examination?       No       Yes         Do you feel you might be at risk for HIV or AIDS?       No       Yes         No       Yes       Don't know         Do you have a communicable infectious disease (such as hepatitis)?       No         No       Yes       Don't know	$\Box$ sinus congestion	$\Box$ change in sexual	$\Box$ recurring thoughts of death or		
Iight-headedness       vision problems       relationships or activities         "black outs"       hearing loss       difficulty concentrating         other symptoms not listed       No symptoms         Are you having difficulty with pain?       No       Yes         Have you ever had a colon or rectum examination?       No       Yes         Do you feel you might be at risk for HIV or AIDS?       No       Yes         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	□ joint swelling				
<sup>(*)</sup> black outs" <sup>(*)</sup> other symptoms not listed <sup>(*)</sup> other symptoms not listed          Are you having difficulty with pain? <sup>(*)</sup> No <sup>(*)</sup> Yes <sup>(*)</sup> Don't know          Have you ever had a colon or rectum examination? <sup>(*)</sup> No <sup>(*)</sup> Yes <sup>(*)</sup> Don't know          Do you feel you might be at risk for HIV or AIDS? <sup>(*)</sup> No <sup>(*)</sup> Yes <sup>(*)</sup> Don't know          Have you ever had tuberculosis (TB) or had exposure to someone who had TB? <sup>(*)</sup> Don't know <sup>(*)</sup> Pon't know          Do you have a communicable infectious disease (such as hepatitis)? <sup>(*)</sup> Don't know <sup>(*)</sup> Pon't know	□ pain or stiffness in joints	□ unusual thirst	□ little interest in		
Are you having difficulty with pain?       No       Yes       Don't know         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	□ light-headedness	$\Box$ vision problems	relationships or activities		
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	□ "black outs"	$\Box$ hearing loss	□ difficulty concentrating		
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		C C	$\Box$ other symptoms not listed		
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         No       Yes       Don't know       Do you have a communicable infectious disease (such as hepatitis)?       No       Yes       Don't know			□ No symptoms		
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         No       Yes       Don't know       Do you have a communicable infectious disease (such as hepatitis)?       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         No       Yes       Don't know       Do you have a communicable infectious disease (such as hepatitis)?       No       Yes       Don't know	Are you having difficulty with pain	? 🗆 No 🗆 Yes 🗆 Don't know	Ŵ		
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	Have you ever had a colon or rectum examination?				
No       Yes       Don't know         Do you have a communicable infectious disease (such as hepatitis)?         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? $\Box$ No $\Box$ Yes $\Box$ Don't know		🗆 No 🗆 Yes 🗆 Don't know			

Patient Signature_	Date:
6 -	

Physician Signature\_\_\_\_\_Date:\_\_\_\_\_

Read and reviewed with patient in detail

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