MAYO CLINIC

Volunteer Services Health Questionnaire

Date: _____

Last Name _____ First Name _____ Middle Name _____

Street Address _____ City _____ State _____

Birthdate _____ Telephone Number _____

Are you currently receiving care from a physician or other health care practitioner? ☐ Yes ☐ No

If yes, please explain:

Please provide us with any health or prescription related information that you believe important for us to know:

Are you allergic to latex? ❑ Yes ❑ No

Other allergies:

Continue on reverse side.

Can you do the following?	Check yes or no:	Describe any limitations:
Lift	❑ Yes ❑ No	
Bend/Twist	❑ Yes ❑ No	
Stoop	❑ Yes ❑ No	
Stand	❑ Yes ❑ No	
Sit	❑ Yes ❑ No	
Reach	❑ Yes ❑ No	
Climb	❑ Yes ❑ No	
Push/Pull	❑ Yes ❑ No	
Walk	❑ Yes ❑ No	

Please describe any hearing limitations or special hearing needs:

Please return form to Volunteer Services. Thank you.

Reset Form Print