



# PATIENT HEALTH HISTORY UPDATE

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Family Physician \_\_\_\_\_

Last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician \_\_\_\_\_

### HISTORY OF PRESENT ILLNESS

Please describe your presenting complaint: \_\_\_\_\_

How long have you had this? \_\_\_\_\_

Do any positions make it feel BETTER? \_\_\_\_\_

Do any positions make it feel WORSE? \_\_\_\_\_

Is this complaint interfering with your:  Work  Sleep  Daily Routine \_\_\_\_\_

What do you think caused the problem? \_\_\_\_\_

### Can you describe your pain in any of the following ways?

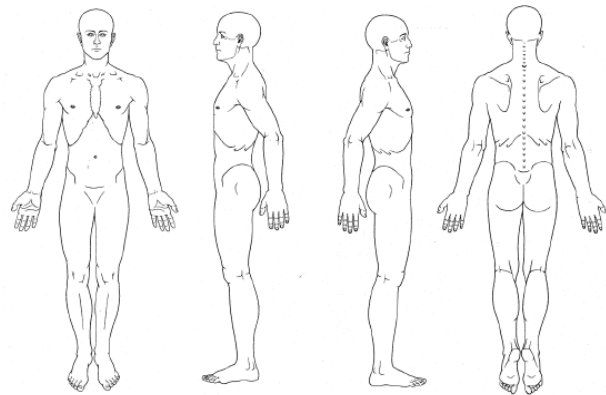
- Burning  Sharp  Stabbing  Dull  Deep  Ache
- Throbbing  Constant  Comes & Goes

### Rate your current pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (most severe)

Do you have any of the following?  No  Yes

Numbness  Weakness  Tingling If yes, where?  
\_\_\_\_\_



**Mark your area of pain with an X**

### REVIEW OF SYSTEMS:

*Circle all of the items that apply to you now and in the past:*

- |                  |                      |                      |                     |                      |
|------------------|----------------------|----------------------|---------------------|----------------------|
| Arthritis / Gout | Depression / Anxiety | Pregnancy            | Headaches           | Heart Disease        |
| Eye Pain/Strain  | Dizziness            | Blurred Vision       | Thyroid Problems    | Chest pain           |
| Gall Stones      | Chronic Cough        | Jaw Pain             | Chronic Fatigue     | Neck Pain/Spasms     |
| Weight Loss      | Leg Cramps           | Weakness             | Seizures            | Shoulder/Elbow Pain  |
| Hypertension     | Stroke               | Kidney Stones        | Shortness of Breath | Irregular Heart Beat |
| Abdominal Pain   | Diabetes             | Groin or Rectal Pain | Female Disorders    | Urinary Problems     |
| Broken Bones     | Digestive Problems   | Nausea/Vomiting      | Irregular Bowels    | ringing in Ears      |
| Mid-Back Pain    | Wrist or Hand Pain   | Low Back Pain        | Hip/Knee/Leg Pain   | Foot or Ankle Pain   |

*I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.*

Patient Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dr. / Staff Initial \_\_\_\_\_