



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?

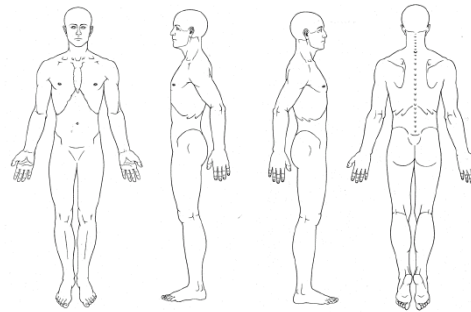
- Burning Sharp Stabbing Dull Deep Ache
- Throbbing Constant Comes & Goes

Rate your current pain on a 0-10 scale:

0 = (no pain) 10 = (most severe) ____/10

Do you have any of the following? No Yes

Numbness Weakness Tingling If yes, where? _____



Office Use Only

Ht. ____' ____"

Wt. ____ lbs.

BP ____/____

Pulse ____ bpm

Temp. ____° F

Mark your area of pain with an X

ROS & PMH:

Click the box of all items that apply to you now and in the past:

- | | | | | |
|---------------------------------------------------|------------------------------------------------|-----------------------------------------------|-------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Frequent Headache | <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Unexplained Falls | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Limb Weakness |
| <input type="checkbox"/> Heat or Cold Intolerance | <input type="checkbox"/> Leg Pain with Walking | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Pins and Needles | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Female Disorders | <input type="checkbox"/> Incontinence |

Recent Surgeries: _____

New Rx Meds: _____

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 ____/____/____