



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?

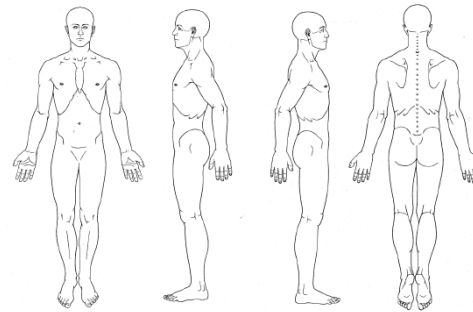
- Burning Sharp Stabbing Dull Deep Ache
- Throbbing Constant Comes & Goes

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?



Office Use Only

Ht. ____' ____"

Wt. ____ lbs.

BP ____/____

Pulse ____ bpm

Temp. ____° F

Mark your area of pain with an X

ROS & PMH:

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

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

Dr. Initial _____