

PATIENT UPDATE/FOLLOW UP HISTORY FORM MR# _____ Today's Date: _____

Patient's Name: _____ DOB: _____ Age: _____ Ht.: _____ Wt.: _____

Primary Care Doctor: _____ Who Referred You? _____

Reason For Today's Visit: _____

Description of Problem: _____

How Long Have You Had the Problem? _____ Severity: 1/2/3/4/5/6/7/8/9/10 Accident/Injury? _____

Quality of Pain: Sharp/Dull: _____ Timing: (Constant/Occasional/Day/Night?) _____

What Makes it Better or Worse? _____

Any Associated Signs/Symptoms (Swelling/Numbness/Tingling?) _____

Has it Occurred Prior to this Episode? _____

Previous Treatment? (Physical Therapy/Injection/Medication) _____

Previous Evaluation?(Lab Work/X-Ray/MRI) _____

Are you taking any medication for this problem? _____

Have There Been Any Changes in Your Medical History Since Last Visit? YES NO If so, circle below.

Diabetes/Hypertension/Heart Disease/Lung Disease/Cancer/Stroke/Kidney Disease/Thyroid/Infection/Seizures

Other Problems or Additional Information: _____

History of Blood Clots or Phlebitis? Yes/No _____

Have There Been Any Changes in Your Family History Since Last Visit? YES NO If so, circle below.

Diabetes/Hypertension/Heart Disease/Lung Disease/Cancer/Stroke/Kidney Disease/Thyroid/Infection/Seizures

Other Problems or Additional Information: _____

Current Medications (Please list with dose if known):

Non-Prescription Medication/Vitamins/Supplements/Herbs: _____

Have You Undergone Any Surgical Procedures Since Last Visit? YES NO

Social History:

Marital Status: Single/Married/Separated/Divorced/Widowed Alcohol: Never/Rarely/Moderate/Daily

Tobacco: Never/Occasionally/Daily/Previously but Quit

Sports/Activities: _____

Hobbies: _____

Allergies: Penicillin/Sulfa/Aspirin/Other: _____

PATIENT SIGNATURE _____

PROVIDER SIGNATURE _____

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Have you experienced any of the following in the past six months? Circle if yes.

Constitutional

Recent weight change
Fever
Fatigue
Headaches

Eyes

Blurred vision

ENT

Hearing loss
Ringing in ears
Earaches
Nosebleed
Sore throat

Cardiovascular

Chest pain
Swelling of feet and ankles

Respiratory

Cough
Shortness of breath
Wheezing

Gastrointestinal

Loss of appetite
Change in bowel movement
Nausea/vomiting
Diarrhea
Blood in stool
Stomach pain

Skin

Rash or itch
Change in skin color
Varicose veins

Genitourinary

Frequent urination
Painful urination
Blood in urine
Incontinence

Neurological

Headache
Dizziness
Seizures
Tremors
Paralysis
Numbness/tingling

Psychiatric

Memory loss/confusion
Nervousness
Depression
Sleep problems

Endocrine

Excessive thirst
Dry skin
Heat/cold intolerance

Hematologic

Slow healing after cuts
Easy bruising

PATIENT SIGNATURE _____

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